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In The
Supreme Court of the United States

CAROLYN G. KOCHERT, M.D.,

Petitioner,

v.

GREATER LAFAYETTE HEALTH SERVICES, INC., *et al.*,

Respondents.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Seventh Circuit

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. Whether lower courts err when they meld the standards for summary judgment under Fed. R. Civ. Proc. 56 and the relevance and reliability requirements for admissibility under Fed. R. Evid. 702?

2. Whether, in order to clarify the distinction between admissibility decisions and evidence sufficient to grant a summary judgment, courts have an obligation to give reasons – which cannot include weighing the testimony – why admissible expert evidence that reaches all material facts necessary to establish a claim for relief under applicable law is not sufficient to avoid summary judgment?

INTERESTED PARTIES

Petitioner Carolyn G. Kochert, M.D., individually.

Respondents Greater Lafayette Health Systems, Inc., an Indiana corporation created 9/21/1998; Anesthesiology Associates, PC, an Indiana domestic professional corporation created 9/29/1989; and John Walling, an individual acting in a representative capacity.

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STATEMENT OF BASIS FOR JURISDICTION

Date of judgment/order sought to be reviewed: September 12, 2006; December 29, 2004 and *Daubert* rulings of November 15, 2004.

Petition for Rehearing and Rehearing en Banc denied October 6, 2006.

28 U.S.C. § 1254(1) confers on this Court jurisdiction to review on a writ of certiorari the judgment in question.

28 U.S.C. § 1291 conferred jurisdiction upon the Court of Appeals for the Seventh Circuit.

STATUTORY PROVISIONS INVOLVED

Fed. Rule of Evid. 702 provides, in relevant part:

> If scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education, may testify thereto in the form of an opinion or otherwise, if (1) the testimony is based upon sufficient facts or data, (2) the testimony is the product of reliable principles and methods, and

(3) the witness has applied the principles and methods reliably to the facts of the case.

Fed. R. Civ. P. 56(c) provides, in relevant part:

. . . The judgment sought shall be rendered forthwith if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law . .

Fed. R. Civ. P. 56(e) provides, in relevant part:

. . . but the adverse party's response, by affidavits or otherwise, provided in this rule, must set forth specific facts showing that there is a genuine issue for trial.

PRELIMINARY STATEMENT

The district court below, after conducting a two-day hearing pursuant to *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 509 U.S. 579 (1993), held that all five[1] of the plaintiff's experts met the standards of relevance and reliability. Subsequently, however, the trial court concluded that this and other evidence was not "persuasive" and granted the defendants' motions for summary judgment. This ruling reflected the court's confusion regarding the force of admissible expert evidence when making determinations regarding the sufficiency of the evidence

[1] Ivankovich's testimony was admitted without challenge. *Infra* at 9-10.

for purposes of summary judgment, and presents this Court with an opportunity to rectify the recurring situation of trial courts overreaching by arrogating to themselves the role reserved by the Constitution to the jury.

The district court did not identify any material facts on which plaintiff had failed to offer adequate proof. Indeed, the district court did not give reasons for why any of the admissible proof was insufficient regarding any particular material facts that were necessary to sustain a claim for relief. The district court, contrary to the most elementary requirements of this Court's precedents, weighed the evidence and concluded that it was not "ultimately persuasive." By so doing, the district court invaded the province of the jury and deprived the plaintiff of a basic constitutional right.

The United States Court of Appeals for the Seventh Circuit ratified and compounded the district court's error by similarly weighing the proffered expert testimony and resolving the case on the merits. Just as had the district court before it, the appellate court melded sufficiency and admissibility when it weighed the expert evidence in support of its conclusion that summary judgment was proper in this case. The Seventh Circuit failed to explain why admissible expert testimony was insufficient to sustain a claim for relief.

This case presents the nether region between admissibility under Rule 702 of the Federal Rules of Evidence and sufficiency under Rule 56 of the Federal Rules of Civil Procedure. Subsequent to *Daubert*, lower courts have increasingly grown confused regarding the relationship between admissibility and sufficiency. Gavil, *After Daubert: Discerning the Increasingly Fine Line Between*

the Admissibility and Sufficiency of Expert Testimony in Antitrust Litigation, 65 Antitrust L.J. 663 (1997). Indeed, according to Judge Barbara Jacobs Rothstein, the current Director of the Federal Judicial Center, a "conflict in the circuits" has developed over whether the inquiry under Rule 702 is separate from any inquiry into sufficiency. Rothstein, *Opinion and Expert Testimony in Federal and State Courts*, Manual for Complex Litigation: Expert Scientific Evidence, SL084 ALI-ABA 189, 202-203 (2006) (citing cases). The disarray in the lower courts creates confusion for litigants regarding where the line is located that divides admissibility and sufficiency. This confusion has manifested itself in the reasons courts give for directing verdicts, explanations that have increasingly reflected a mixture of admissibility and sufficiency bases. This case illustrates this confusion.

This case also presents the exceedingly important question of whether courts must give reasons why admissible expert evidence that reaches all material facts necessary to establish a cause of action under applicable law is not sufficient to avoid summary judgment. To the extent that the boundary between admissibility and sufficiency is not well marked, lower courts can make plain the bases for their holdings by explaining how they reached their judgments. It has long been standard practice among courts to give reasons for admitting or excluding expert evidence under *Daubert* and Rule 702 (*Goebel v. Denver and Rio Grande Western R.R. Co.*, 215 F.3d 1083, 1088 (10th Cir. 2000) ("[W]e specifically hold that a district court, when faced with a party's objection, must adequately demonstrate by specific findings on the record that it has performed its duty as gatekeeper.")), just as

there has been a long tradition of giving reasons explaining why admitted evidence was not sufficient to establish a claim for relief. *Wildbur v. Arco Chemical Co.*, 974 F.2d 631, 644 (5th Cir. 1992) ("[A] district court [must] explain its reasons for granting summary judgment in sufficient detail . . . to determine whether the court correctly applied the appropriate test.")

It appears, therefore, that the procedural requirements to get a case before a jury have become muddled. This muddle sows confusion among litigants regarding the standards that they must meet both in responding to expert testimony challenges and in opposing motions for summary judgment. Because this case presents such an unusual circumstance – summary judgment granted in the teeth of admitted expert testimony – it presents a unique vehicle for this Court to visit the admissibility and sufficiency intersection. In short, Petitioner urges the Court to untangle the conflict between admissibility and sufficiency and to also make plain the need for lower courts to give reasons for their rulings. In this case, this practice would have resulted in the lower courts giving reasons for why admitted expert testimony that reached all material facts in dispute was not sufficient to overcome summary judgment. Forcing trial courts to articulate reasons for allowing summary judgments in the face of admitted expert testimony on burdens of proof consistent with prevailing law will also (1) lay out a template for future litigants to follow concerning what is expected of them; and (2) focus reviewing courts on whether summary judgment's sufficiency standard has been met under such circumstances.

STATEMENT OF THE CASE

1. Factual Background

Carolyn G. Kochert, M.D. ("Petitioner") is a physician, who has practiced medicine in Lafayette, Indiana since 1985. She has all appropriate licensures and privileges to practice anesthesiology at the Respondent Greater Lafayette Health Systems' ("GLHS") two hospitals, Home Hospital ("HH") and St. Elizabeth's Medical Center ("SEMC"). Her licenses and privileges have never been revoked, suspended, modified or in any way challenged by governing authorities at any time. Throughout the entire time period of this case, and through the filing of this Petition, Petitioner remains in Lafayette as a competitor in anesthesiology. She has been sought out by patients and physicians alike for her abilities and expertise.[2] She has held numerous positions on hospital staffs, including President of Home Hospital. She was also Outstanding Business and Professional Woman of the Year in her community.

An exclusive dealing, no-bid contract was entered into between HH and Respondent, Anesthesiology Associates, PC ("AA") as of September 1, 1994. Respondent John Walling ("Walling"), then president of HH, executed the exclusive contract on behalf of HH; Kenneth Bochenek, M.D. ("Bochenek"), executed the contract on behalf of AA as its president. The contract required that those not within the group be required to execute subcontracts with AA. Petitioner did so. This exclusive contract was periodically renewed over the next decade, again without bidding.

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[2] Over four dozen affidavits were filed with the district court to support this.

In October, 1997, HH and SEMC announced their merger, with GLHS becoming the new entity. In the fall, 1997, considerable animus developed between Bochenek and Walling, on the one hand, and Petitioner, on the other, over patient care issues. Walling became CEO of GLHS in 1998. GLHS accepted assignment of the exclusive contract in November, 1998.

In December, 1997, Petitioner was advised by Bochenek that her subcontract would not be renewed, effective March 1, 1998. This was the first occasion that a competitor in anesthesiology was excluded from the market. Both Walling and Bochenek also testified to the non-existence of the exclusive arrangement requiring these subcontracts as of March 1, 1998.

In April, 1999, GLHS closed the obstetrical unit, including labor and delivery, at SEMC, and consolidated it with the unit at HH. After this closure, Petitioner could not provide obstetrical anesthesia to patients at GLHS.

In or about 2000, a multi-specialty physician practice and outpatient facility opened, called Unity Healthcare ("Unity"). Petitioner became a member of Unity. GLHS considered Unity to be a competitor and consequently its member physicians to be competitors offering competitive services to GLHS and its exclusive provider of anesthesia services.

As a result of the animus that occurred with Petitioner, and the operation of the exclusive contract, Petitioner was forced to look for other work in the field of medicine besides anesthesiology as early as March 1, 1998. Because of deep roots in the community, and raising six children with her husband where she was the primary means of financial support, she chose to train for, and then

establish, a pain management practice in the Lafayette market. She continued consulting and interacting with nursing personnel and physicians at GLHS, as well as seeing/treating patients there, even to this very day. Though she established a pain management practice full time as of the fall, 2000, she occasionally rendered anesthesia services at Unity. (Petitioner was, nonetheless, ready, willing and able to continue practicing anesthesiology full time at GLHS, as late as 2002-2003. Her written requests to do this during these time periods were rebuffed by the GLHS administration.)

28 U.S.C. § 1337(a) and 28 U.S.C. § 1331 conferred original subject matter jurisdiction and 28 U.S.C. § 1367(a) conferred supplemental jurisdiction upon the United States District Court, Northern District of Indiana, Hammond Division at Lafayette. Venue was established pursuant to 28 U.S.C. § 1391(b).

2. Procedural History

Petitioner filed a lawsuit on May 8, 2001 pursuant to §§ 1 and 2 of the Sherman Antitrust Act, 15 U.S.C. § 1 *et seq.*, and analogous sections of the Indiana Code, I.C. 24-1-2-7 for violations of I.C. 24-1-2-1, and 24-1-2-2. Leave was granted to file a First Amended Complaint on September 18, 2001.

Respondents filed Fed. R. Civ. P. 12(b)(6) motions to dismiss based on lack of antitrust standing and antitrust injury. The trial court denied these motions on January 11, 2002. App. 64-69.

In their answers to both Petitioner's complaint and amended complaint, Respondents admitted that their exclusive dealings involved interstate commerce.

On May 28, 2002, the trial court granted Petitioner's request for a jury trial. App. 70.

Douglas Eberle, GLHS' CEO after Walling retired, admitted that economics for GLHS played into contracts for anesthesiology; this was favorable for GLHS because third party payors providing patients to GLHS would use GLHS as a preferred provider. App. 128-131.

In the course of discovery, Petitioner identified five expert witnesses who would testify on her behalf: Bruce Seaman, PhD ("Seaman") and Paul Gertler, PhD ("Gertler") – economists; Stephen Minore, M.D. ("Minore"), Anthony Ivankovich, M.D. ("Ivankovich"), and, by way of affidavit relied upon by Minore, Karen Williams, M.D. – all testifying to quality of care; and Cornelius Hofman, M.B.A. ("Hofman"), who testified on Petitioner's damages.

Respondents disclosed as their experts economists David M. Eisenstadt, PhD ("Eisenstadt"), and Edward Heiden, PhD ("Heiden"), Bryan Liang, M.D., J.D., PhD ("Liang") and David Barbara, M.D. ("Barbara"). Eisenstadt and Heiden testified to antitrust standing, injury and markets; Liang reported on injury to competition, quality of care and pricing; and Barbara addressed anesthesia practice and quality of anesthesia care at GLHS.

Respondents moved to strike the testimony of Seaman, Gertler, Minore and Hofman pursuant to *Daubert*. Petitioner challenged Barbara's testimony pursuant to *Daubert* as well. Following extensive pleadings (29 docket entries), the trial court issued its *Daubert* rulings on November 15,

2004, denying Respondents' challenges. App. 35-63. Petitioner's challenge to Barbara was similarly denied.

On December 29, 2004, the district court granted Respondents' pending motions for summary judgment. App. 18-34.

The Seventh Circuit Court of Appeals affirmed the trial court's decision on September 12, 2006 (App. 1-17), and, in so doing, allowed to stand the trial court's rulings admitting the testimony of Seaman, Gertler, Minore, and Hofman.

A Petition for Rehearing and Rehearing en Banc was denied on October 6, 2006. App. 72.

3. Reasons for Allowing Writ

Weighing admitted expert testimony in the face of summary judgment without explaining why such testimony is insufficient to avoid a judgment as a matter of law illustrates the tension that now exists between lower courts' use of the *Celotex* trilogy[3] and the purpose and

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[3] *Celotex Corp. v. Catrett*, 477 U.S. 317, 323, 106 S. Ct. 2548 (1986); *Matsushita Electric Industrial Co. v. Zenith Radio Corp.*, 475 U.S. 574 (1986); *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 250-251, 106 S. Ct. 2505 (1986).

It should be noted explicitly that *Matsushita* is inapposite to the situation presented in the instant case. A key point in contention in that case was the value of the "DePodwin Report," which Justice White, dissenting, believed "alone creates a genuine factual issue. . . ." *Matsushita*, 475 U.S. at 603 (White, J., dissenting). This Court, however, found the district court's view of the DePodwin Report persuasive. *Id.* at 594, n.19. The district court had found the report to be inadmissible under Rule 702, not insufficient for purposes of summary judgment. *Matsushita*, therefore, represents an instance (albeit before *Daubert*) of the usual situation in which exclusion of

(Continued on following page)

effect of the *Daubert* decision. In short, the lower courts in this case applied an admixture of evidentiary and sufficiency constructs to weigh evidence and direct a finding against Petitioner. Lower courts should make clear the bases for their rulings, whether on evidentiary or sufficiency grounds. Such clarity in this case would have made plain that the Petitioner's admitted expert testimony more than adequately satisfied the demands of summary judgment. In granting this Petition, this Court will be afforded the opportunity to address these issues and thereby clarify the intersection of Rule 702's admissibility requirements and Rule 56's sufficiency.[4]

ARGUMENT IN SUPPORT OF PETITION

A. A lower court has a basic obligation to provide reasons explaining why it granted summary judgment notwithstanding the admissibility of expert opinion that reaches all material facts necessary to establish a cause of action.

The principle behind this Petition is at bottom a practical one. The lower courts failed to give Petitioner

expert testimony leads inexorably to summary judgment. In the instant case, of course, all of the Petitioner's experts were admitted.

[4] On November 27, 2006, this Court heard oral arguments in *Bell Atlantic v. Twombly* (*cert. granted* 6-26-2006 (126 S. Ct. 2965)) ("*Bell Atlantic*"). The instant case is a logical next step for this Court to tackle after confronting in *Bell Atlantic* the importance of careful application of pleading and proof requirements in complex and costly litigation. Whereas in *Bell Atlantic* this Court will clarify the terrain surrounding antitrust pleading requirements, the instant case presents the opportunity for this Court to clarify the terrain at the intersection of admissibility and sufficiency.

clear guidance regarding what is necessary to have a jury hear her claim. The requisites on the road to a jury trial to date have been many[5] and, most unfortunately, their results have been inconsistent with the final outcome. In particular, the courts below blended admissibility and sufficiency principles to sustain the final determination that resulted in the grant of summary judgment for the defendants. With this Petition, we ask this Court to reverse the judgment below, clarify the different standards that apply to admissibility decisions and summary judgment determinations, and allow Petitioner her day in court.

It is hornbook law that the procedural standards differ at the two junctures of admissibility and sufficiency, but are so closely related that considerable confusion exists in their application. Under Rule 702, and as first set forth in *Daubert*, the proponent of expert testimony has the burden to demonstrate that expert opinion is based on good grounds. The judge as gatekeeper is responsible for evaluating the reliability of the basis for proffered opinion. This is an exacting standard. *See Weisgram v. Marley Co.*, 528 U.S. 440, 455 (2000) ("Since *Daubert*, . . . parties relying on expert evidence have had notice of the exacting standards of reliability such evidence must meet.") The

[5] They have included the following: (a) surviving Fed. R. Civ. P. 12(b)(6) challenges to her lawsuit; (b) having to identify and disclose expert witnesses to fortify her burdens of proof consistent with prevailing law; (c) filing multi-page memoranda in opposition to Respondents' motions to strike expert testimony pursuant to *Daubert* challenges; (d) filing a memorandum of law requested by the district court as to Seventh Circuit law on *Daubert*; (e) participating in lengthy, two days of hearings pursuant to *Daubert* on Respondents' motions to strike testimony; and (f) overcoming *Daubert* challenges.

proponent bears the burden of proof to demonstrate the reliability of his or her expert's testimony. Moreover, on appeal, the trial court's decision to admit or exclude the evidence is given deference. The evidentiary requirements for expert opinion are not easily met. Yet, in this case, the district court ruled that all of Petitioner's experts were admissible, and the Seventh Circuit did not find this ruling to be an abuse of discretion.

Summary judgment erects a very different edifice. A summary judgment is permitted only if, when all of the facts are construed in the light most favorable to the non-moving party, without making credibility determinations or weighing the evidence, there is "no genuine issue as to any material fact and . . . the moving party is entitled to a judgment as a matter of law." Fed. R. Civ. P. 56(c); *Celotex Corp. v. Catrett*, 477 U.S. 317, 322-323 (1986); *Reeves v. Sanderson Plumbing Products, Inc.*, 530 U.S. 133, 150 (2000). Although summary judgment puts significant demands on the parties, it is designed to ensure merely that the parties' cases are sufficiently worthy to proceed to trial.

At the same time, while admissibility and sufficiency occupy separate procedural pedestals, they are closely inter-related. *Daubert* serves to ensure that there is some reliable and valid basis for proffered expert testimony. In effect, admissibility decisions are grist for summary judgment's mill. If any of the essential parts of a party's case fails *Daubert*, summary judgment clears the court's docket of these deficient cases. But district courts have taken their gatekeeping role beyond the expanse of *Daubert* to where they are deciding material questions of fact reserved for a jury. Equally true, though, is that when

all of the essential parts of a party's case pass *Daubert*, this will virtually always be enough to proceed to trial.

Indeed, summary judgment often follows a district court's exclusion of expert testimony, since this tends to render the non-moving party's proof insufficient to create a genuine issue as to any material fact. When expert testimony is deemed admissible, of course, it is invariably enough to create a dispute about a material fact. The more routine situation involves cases in which expert testimony may be admissible, but there remain facts on which the non-moving party has not produced expert or non-expert evidence sufficient to create a genuine issue. In fact, a thorough search of the post-*Daubert* literature reveals only four cases in which summary judgment was granted in the teeth of admissible expert testimony, and these four are instances of the more generally observed phenomenon in which no expert proof was offered as to one or more required facts.[6] This case, therefore, presents the situation

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[6] These cases are *Barnes v. The Kerr Corp.*, 418 F.3d 583 (6th Cir. 2005); *Morgan v. United Parcel Service of America, Inc.*, 380 F.3d 459 (8th Cir. 2004); *Bailey v. Allgas, Inc.*, 284 F.3d 1237 (11th Cir. 2002); and *Rebel Oil Co., Inc. v. Atlantic Richfield Co.*, 146 F.3d 1088 (9th Cir. 1998) ("*Rebel Oil*"). A close examination of these decisions reveals that they are not precedent for granting summary judgment in the face of previously admitted expert testimony.

In *Barnes*, the Sixth Circuit found that, despite the admissibility of the non-moving party's experts, he had failed to establish a required element of his proof – causation – and that, in any event, the numerous warnings provided by [the moving party] " . . . were adequate as a matter of law" *Barnes*, 418 F.3d at 591.

In *Morgan*, the Eighth Circuit initially noted that the district court had granted summary judgment without reaching the moving party's objections to the opponent's expert testimony. *Morgan*, 380 F.3d at 463. The Eighth Circuit, however, surmised that the district court had been troubled by methodological weaknesses in the non-moving party's

(Continued on following page)

in which summary judgment was granted notwithstanding admissible expert testimony on all of the facts necessary to establish a claim for relief under applicable law.

1. Conflict and Confusion Between Admissibility and Sufficiency

While this case is almost unique in its presentation of the issue, the issue itself is hardly novel, or even unusual. Just as occurred here, the lower courts often confuse admissibility and sufficiency. Gavil, "*After Daubert . . . ,*" *supra* at 3-4, 65 Antitrust L.J. at 704 (in *Matsushita*,

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expert testimony concerning certain regression analyses conducted – an admissibility consideration. The *Morgan* court then proceeded to review the lower court's ruling *de novo*, since no admissibility determination had been made below, and affirmed the lower court's summary judgment ruling.

In *Bailey*, the trial court there had found the proffered expert to be inadmissible (*Bailey*, 284 F.3d at 1246), and the Eleventh Circuit itself found the expert opinion to be inconsistent with the facts that were not controverted. *Id.* at 1255.

In *Rebel Oil*, the moving party argued that the district court acted properly in finding the non-moving party's expert testimony was admissible, but that summary judgment was nonetheless appropriate. *Rebel Oil Co., Inc.*, 146 F.3d at 1096-1097. A closer look at *Rebel Oil*, however, indicates that, like *Barnes*, the case illustrates the circumstance when the complaining party is unable to establish a required element of his proof, and, thus, the expert testimony is not sufficient as a matter of law. 146 F.3d at 1097; *see Rebel Oil Co., Inc. v. Atlantic Richfield Co.*, 957 F. Supp. 1184, 1202 (D. Nev. 1997) (expert's measurement of marginal cost of gasoline contrary to law (509 U.S. at 223)). Moreover, the *Joiner* language that the Ninth Circuit relied upon to define their sufficiency analyses for purposes of summary judgment, in fact, defines the admissibility standard under *Daubert*. When a court concludes that "there is simply too great an analytical gap between the data and the opinion proffered," there is "nothing in either *Daubert* or the Federal Rules of Evidence [that] requires a district court to *admit* [that] opinion evidence." *General Electric Co. v. Joiner*, 522 U.S. 136, 146 (1997) (emphasis added).

admissibility and sufficiency collapsed into a single inquiry). In the more typical case, courts rule on admissibility challenges by incorporating the demands of sufficiency into the admissibility determination. As noted above, Judge Rothstein has described the conflict that exists among the lower federal courts regarding whether the admissibility determination is separate from the sufficiency judgment. *Supra* at 4; *see, e.g.*, *In re Joint Eastern & Southern Dist. Asbestos Litig. v. U.S. Mineral Products Co.*, 52 F.3d 1124, 1132-1133 (2d Cir. 1995) (sufficiency inquiry lies further down the litigational road and is separate from admissibility); *Ambrosini v. Labarraque and The Upjohn Co.*, 101 F.3d 129, 132, 134-135, 141 (C.A. D.C.C. 1996) (if expert testimony is reliable and "fits" an issue in the case, the trier of fact should weigh it); and *Norris v. Baxter Healthcare Corp.*, 397 F.3d 878, 884 (n.2) (10th Cir. 2005) (relevant testimony logically advances a material aspect of the case). Indeed, the Seventh Circuit's decision in the instant case is in direct conflict with the Second Circuit's ruling in *In re Joint Eastern & Southern Dist. Asbestos Litig.* In the latter, the Second Circuit reversed a district court's judgment as a matter of law, finding that it had imported *Daubert* gatekeeping principles into its sufficiency evaluation. In that case, as is true here, the district court weighed the evidence and directed a verdict notwithstanding the admissible expert opinion. But in that case, the Second Circuit reversed the trial court's overreaching, concluding that, "*Daubert* left the traditional sufficiency standard intact." 52 F.3d at 1132. In the instant case, in contrast, the Seventh Circuit affirmed the trial court's inflation of the sufficiency standard, thus rejecting the "[p]assages in *Daubert* regarding sufficiency [that] sounded a tone of optimism about juries' abilities to sort out the veracity of competing scientific evidence." *Id.*

Such disarray in the lower courts creates confusion for litigants regarding where the line is located that divides admissibility and sufficiency. It was just this sort of confusion that led to the holdings below. Much clarification would come by this Court addressing admissibility and sufficiency standards, and then mandating that lower courts state plainly the reasons for their procedural decisions, keeping admissibility and sufficiency separate. There is precedent for this.

It has long been a tradition in summary judgment cases for courts to give reasons for their decisions. *See, e.g., U.S. v. Continental Oil Co.*, 377 U.S. 161, 162 (1964) (separate op. of Harlan, J.); *Vermont Teddy Bear Co., Inc. v. 1-800 Beargram Co.*, 373 F.3d 241, 244-245 (2d Cir. 2004); and *Wildbur, supra* at 5. Similarly, appellate courts have regularly insisted that district courts make clear their bases under *Daubert* for admitting or excluding expert opinion. *Goebel, supra* at 4. Although appellate courts owe deference to trial court rulings on admissibility, no effective review can take place if lower courts do not explain the reasons for their admissibility decisions in the summary judgment context.

2. Fit, Materiality and the "Space" Between Admissibility and Sufficiency

There is good reason to suppose that it would be exceedingly rare for expert testimony to be admitted regarding all issues necessary to establish a claim for relief, yet for summary judgment to be imposed. Built into the *Daubert* and Rule 702 structure is the requirement of relevancy, which this Court defined as "fit." *Daubert*, 509

U.S. at 591. On remand in *Daubert*, the Ninth Circuit discussed this relevancy requirement as follows:

> We must ensure that the proposed expert testimony is "relevant to the task at hand," *Id.* at 2797, i.e., that it logically advances a material aspect of the proposing party's case. The Supreme Court referred to this second prong of the analysis as the "fit" requirement. *Id.* at 2796.

Daubert v. Merrell Dow Pharmaceuticals, Inc., 43 F.3d 1311, 1315 (9th Cir. 1995) (Daubert "II"). In short, if proffered expert opinion does not advance a material aspect of the party's case, it is not relevant in the first place. Admitted evidence, as a consequence, is already well on its way to satisfying Rule 56.

In *Daubert* itself, this Court also gave notice to the space between admissibility and sufficiency, while recognizing that it was not capacious. This Court assured the parties, particularly Respondent in that case, that the ruling would not lead to a "free-for-all." If the threshold admissibility requirements did not exclude bad science, this did not mean that "befuddled juries" would be "confounded by absurd and irrational pseudoscientific assertions." *Daubert*, 509 U.S. at 595. This Court explained that other procedural hurdles could guard against such pseudoscience, stating as follows:

> [I]n the event the trial court concludes that the scintilla of evidence presented supporting a position is insufficient to allow a reasonable juror to conclude that the position more likely than not is true, the court remains free to direct a judgment, Fed. R. Civ. P. 50(a), and likewise to grant summary judgment.

Daubert, 509 U.S. at 596.

Clearly, this Court considered the prospect that expert evidence would be admissible but insufficient to proceed to trial to be extremely rare. Indeed, this Court's earlier statement in the same paragraph indicates what should happen in the ordinary course of the proceedings after expert testimony is deemed admissible: "Vigorous cross-examination, presentation of contrary evidence, and careful instruction on the burden of proof are the traditional and appropriate means of attacking shaky but admissible evidence." *Daubert*, 509 U.S. at 596.

In this case, there has been no suggestion that the Petitioner's proof is "shaky" or constitutes a mere "scintilla of evidence." The district court found that Petitioner's expert testimony overcame the substantial demands of *Daubert* and was highly probative of the central concerns presented by the claim for relief. *See, e.g.*, App. 37 (defining the markets is a central issue). As a general statement of the law following a *Daubert* challenge, then, if expert testimony is found admissible by a preponderance of the evidence (*i.e.*, is relevant and reliable, and would assist the trier of fact) – and such testimony does not deviate from prevailing law and supports elements of the burden of proof (or in conjunction with other proofs) – then that testimony creates a factual dispute and is material for a jury to consider in a jury case. Such testimony is sufficient to overcome a pending motion for summary judgment.

The district court in this case found all of the Petitioner's proffered expert testimony to be admissible under *Daubert*. This holding was left undisturbed by the Seventh Circuit. Yet these courts concluded, notwithstanding admissible evidence on all issues necessary to establish a claim for relief under prevailing law, that summary judgment for the Respondents was proper. The lower

courts did not give reasons explaining why the admissible expert evidence was not sufficient to allow this case to proceed to trial. Instead, they effectively weighed the expert testimony, and chose between alternative theories offered by the experts for the respective sides, in reaching their summary disposition of this case. This was error. As the next sections demonstrate, on each and every point on which the lower courts rested their analyses, there existed admissible expert opinion that was material to aid the jury in deciding whether Petitioner had met her burdens. Unfortunately, this is not an error that merely plagues this case, but one that occurs in district courts with increasing frequency. *See generally*, Gavil, *supra* at 3-4; Rothstein, *supra* at 4.

B. The lower courts' analyses of antitrust standing and injury failed to give reasons why admitted expert testimony was insufficient for a jury to decide standing.

As a preliminary requirement, Petitioner established Article III standing. The Seventh Circuit specifically so found ("Kochert can construct a reasonable causality chain linking her injury to defendants' actions." App. 8), and the district court held that Petitioner sufficiently pled antitrust standing and injury when it denied Respondents' 12(b)(6) motions. App. 64-69. It thus became a matter of proofs to determine whether these activities were anticompetitive, enabling Petitioner to proceed to a jury on antitrust standing.

According to Areeda and Hovenkamp, the basic antitrust standing requirements that must be proven by plaintiffs are as follows: (a) injury to "business or property"; (b) injury-in-fact "by reason of" the antitrust violation [injury caused by violation]; (c) proximity [injury not

unduly remote from the violation, taking into account risk of duplicative recovery, and alternative plaintiffs]; (d) antitrust injury [injury intended to be prevented by the antitrust laws – harm to competition]; and (e) cognizable injury and reasonably quantifiable damages [taking into account whether damages were speculative and the complexity of apportioning them]. Areeda and Hovenkamp, *Standing of Private Plaintiffs*, Fundamentals of Antitrust Law, ¶ 3.01(c)-(d), at 3-7 to 3-12 (Aspen Publ. (2006 Suppl.)); *see Assoc. Gen'l Contractors v. California Council of Carpenters* ("*AGC*"), 459 U.S. 519 (1983). Petitioner's proof fully met these requirements.

As a general matter, principles of causation and proximate cause borrowed from tort law are used for antitrust standing analysis. *Anza v. Ideal Steel Supply Corp.*, 126 S. Ct. 1991, 1996 (2006); *see Jack Walters & Sons Corp. v. Morton Building, Inc.*, 737 F.2d 698, 708-709 (citing to *Gorris v. Scott*, 9 L.R. Ex.-125 (1874) (7th Cir. 1984)). Contrary to what the Seventh Circuit did in this case, once sufficient allegations with supporting proofs have been presented, in a jury case, the jury determines antitrust standing. *See Cargill, Inc. v. Monfort of Colorado, Inc.*, 479 U.S. 104, 111 (1986); *AGC*, 459 U.S. 519, 521, 545-46 (1983); *Blue Shield of Va. v. McCready*, 457 U.S. 465, 471 (1982); *NicSand, Inc. v. 3M Co.*, 457 F.3d 534, 548-549 (6th Cir. 2006); *Unitherm Food Systems, Inc. v. Swift-Eckrich, Inc.*, 375 F.3d 1341, 1349 (Fed. Cir. 2004) (market definition and antitrust injury are factually intensive inquiries for a jury's determination) (*rev'd on other grds.*, 126 S. Ct. 980); *Bourns, Inc. v. Raychem Corp.*, 331 F.3d 704, 710-711 (9th Cir. 2003) (jury determines date for antitrust standing). Antitrust standing is thus no different than a garden variety tort case requiring expert

testimony, or other appropriate admissible proofs, to establish causation as an element by law. If proofs on it are lacking, then, of course, a court can determine as a matter of law that plaintiff has failed in her burden. *See, e.g., Ambrosini* at 141, *supra* at 16 (admitted testimony on causation constitutes evidence to raise questions of material fact to defeat summary judgment). But if proofs are present, as here, then a jury makes the decision.

In the instant proceeding, the appellate court stated that either the 1998 denial of renewal of Kochert's subcontract constituted a part of the anticompetitive scheme, or it did not. If it did not, it is not the starting point for the anticompetitive scheme. App. at 12. But Petitioner's expert, Seaman, used an analysis starting in 1997 (App. 89) that established a spectrum of anticompetitive behavior commencing in 1998 and culminating in 2001 (App. 91-93, 133-134, 137). Moreover, Respondents' exclusive dealing arrangement excluded Petitioner as a direct competitor and entailed the use of Respondents' market power (App. 89, 82-86, 76-78). Thus, Seaman's admitted testimony stated that in this case, 1998 was the starting point of the anticompetitive harms, and is in accord with this Court's recognition that events over time can constitute a violation of antitrust law. *Aspen Highlands v. Aspen Skiing Co.*, 738 F.2d 1509 (10th Cir. 1984), *aff'd*, 472 U.S. 585 (1985); *Continental Ore Co. v. Union Carbide & Carbon Corp.*, 370 U.S. 690, 693-695, 699 (1962).

The appeals court, *sua sponte*, termed what occurred in 1998 as " . . . simply staffing decisions made solely by parties without market control." App. 13. Seaman, though, opined and calculated that Respondents had market control. He never testified, nor did any of Petitioner's experts, that it was a "staffing decision." App. 82-86, 76-78.

Also, the appellate court never stated what constituted market control; it simply concluded that there was no market control. Without knowing the parameters of market control for a given time period, there can never be a determination of market "as a matter of law." More importantly, market definition is for a jury to determine. *Unitherm, supra* at 21.

The appellate court further determined that Petitioner was a direct competitor, but nevertheless held that she was not an appropriate party to challenge the anti-competitive effects of the exclusive dealing scheme of the Respondents. Seaman concurred that Petitioner was indeed a competitor, but, consistent with prevailing law, categorized her as an appropriate, indeed essential, party to enforce antitrust law in the context of exclusive dealing. App. 80. ["The Areeda/Hovenkamp treatise states the rule categorically: 'a rival has clear standing to challenge the conduct of rival(s) that is illegal precisely because it tends to exclude competitors from the market.' Antitrust Law 2002, ¶ 348a . . . The justification for competitor standing in exclusive dealing cases is not that exclusive dealing liability exists for the benefit of competitors. It is rather that when unlawful exclusive dealing occurs, competitors are efficient advocates of consumers' . . . interests . . . " *NicSand,* 457 F.3d at 549.]

The Seventh Circuit panel also found that Petitioner left the market in 2001. The two primary hospitals in the market merged into GLHS in 1998 and created substantial market power. They then began consolidating services, *e.g.* birthing, into a single hospital from which Petitioner was excluded. It was reasonable to foresee, as Petitioner saw, that further foreclosures of competition would occur by the actions of Respondents – which indeed took place – as

evidenced by the complete exclusion of Petitioner and other competitors to AA no later than 2001. This Court has long since recognized that competitors have standing whenever they can show that they are being excluded, whether fully or partially, in ways that harm competition, and not just the competitor. *Brunswick Corp. v. Pueblo Bowl-O-Mat, Inc.*, 429 U.S. 477, 489 (n.14) (1977). ("But competitors may be able to prove antitrust injury before they are actually driven from the market and competition is thereby lessened.") Even if she left the market before 2001, Petitioner would still have had standing since Seaman's admitted testimony, combined with that offered by Minore, Gertler and Ivankovich, found adverse competitive effects as early as 1998. Hofman's damage calculations commenced in 1998 as well.

Indeed, during and after 2001, Petitioner continued to be ready, willing and able to reenter the market and thus satisfied the well-recognized "intention and preparedness" doctrine, *e.g., Grip-Pak, Inc. v. Illinois Tool Works, Inc.*, 694 F.2d 466, 475 (7th Cir. 1983). *See* App. 8. Petitioner had the qualifications, licensures, physical presence in the market, and intention to practice anesthesia services full time in 2001 and thereafter. Only Respondents' exclusive dealing arrangement prevented her and other competitors from serving the market. Petitioner alone suffered damages exceeding $1.0M through 2018. App. 124. Petitioner had standing in 2001 and thereafter as well.

Furthermore, to establish antitrust injury, a litigant must show acts that reduce consumer welfare, such as through reduced quality of care, an increase in pricing, or a reduction in output. *Chicago Prof. Sports Ltd. P'ship. v. NBA*, 961 F.2d 667, 669 (7th Cir. 1992); *Consolidated Metal Products, Inc. v. Am. Petroleum Institute*, 846 F.2d

284, 291-294 (5th Cir. 1988); *Lie v. St. Joseph Hospital,* 964 F.2d 567, 570 (6th Cir. 1992); *New York Medscan LLC v. New York University School of Medicine*, 430 F. Supp.2d 140, 146, 150 (S.D.N.Y. 2006). Petitioner established anti-trust injury as early as 1998 by showing through her experts – Minore, Gertler, Seaman and Ivankovich – that competition was harmed, and thus consumers were adversely impacted, through decreased quality of care (App. 110-118, 121) (quality of care provided by the exclusive group was inimical to patient care; the conduct of the group constituted gross negligence; and the exclusive group abused the exclusive contracts it had, per Minore); 125-126 (an anesthesiologist leaving a patient unattended in an operating room deviates from standards of care for anesthesiologists and is like an airline pilot falling asleep in flight, only to awaken to land the plane, per Ivankovich); increased pricing (App. 98-99 (20% price increase, per Seaman)); App. 101 (no cost savings or efficiencies with exclusive arrangements, per Gertler) 108-109 (13-26% price increase where norm is 6%, per Gertler); and decreased output (several deponents and GLHS' consultant's report in 2004).

Moreover, motive to monopolize was established by Seaman. App. 73-75, 77-79, 83-88. (GLHS sought to reduce the risk of competition for overall services at its hospitals and AA obtained the benefit of eliminating competition from anesthesiologists.)

There was also no potential for duplicative recovery or complex apportionment of damages, because Petitioner's injury (economic loss), measured by Hofman (App. 123-124), was not passed along to others.

Petitioner, therefore, satisfied each element of standing, particularly with admitted expert testimony. *See also* App. 132-139. However, the court of appeals decided she was not a proper party to challenge Respondents' exclusive dealing scheme. This result stems from the refusal to acknowledge the testimony of Petitioner's experts who provided support for all the elements necessary to establish antitrust standing and so should have warranted presenting this issue to the jury. Without deference to this type of admitted proof, Petitioner could not demonstrate that material questions of disputed facts existed even though she was a direct competitor excluded by those with market power in markets established by admitted expert testimony, and within a class of individuals, competitors or consumers, that this Court has identified as being among those motivated to enforce the antitrust laws. *AGC*, 459 U.S. at 539, 542.

Consequently, the Petitioner finds herself in the ironic and untenable position of having proffered expert testimony that was relevant to antitrust standing, and which was admitted to prove antitrust standing, but whose suit was dismissed on the basis that she provided insufficient proof of antitrust standing. This outcome begs for explanation. Why was relevant and reliable evidence on antitrust standing not sufficient to reach a jury in this case? Before proceeding to dismiss Petitioner's case, basic principles of fairness should require courts to explain why judgment as a matter of law is proper. If a court cannot answer this elementary question, the question should be submitted to the jury for decision. That is in accord with this Court's holdings. *See Unitherm Food Systems, Inc. v. Swift-Eckrich*, 126 S. Ct. 980, 986 (2006) (citing to *Baltimore & Carolina, Inc. v. Redman*, 295 U.S. 654, 658 (1935) (courts

do not serve as replacements to juries that determine issues of fact).

C. Admitted expert testimony and other proofs contradicted the courts' findings that Petitioner had not met her burden to provide sufficient evidence.

Besides antitrust standing and antitrust injury, every other point put forth by the lower courts indicating that Petitioner did not meet her burdens of proof is contradicted by admitted expert testimony and other proofs. For example, the district court accepted Seaman's market definitions for *Daubert* purposes, but then went too far by saying they were unproven for sufficiency purposes. It also found that Petitioner did not establish GLHS' economic interest in the exclusive anesthesia dealing scheme to support an unlawful tying arrangement; yet GLHS' CEO, Eberle, specifically stated that GLHS had such an economic interest and would benefit by it. App. 128-131. The circuit court said Respondents had no market control, but allowed to stand Seaman's statement showing to the district court's satisfaction that Respondents had a monopoly in their markets. The Seventh Circuit's declaration that the exclusive dealing arrangement had not caused prices to increase above normal levels totally ignored Gertler's testimony that it did so by over 25%. In addition, the appellate court was critical of anecdotal evidence showing diminished quality of care as an indicator of harm to competition, but it did not find manifest error in the district court's conclusion that such evidence was relevant and reliable, and that any of its limitations would be tested on cross examination at trial. All this, and more, is set forth in the Appendix, at 132-139.

D. Did the trial and appellate courts below err in weighing the persuasiveness of admitted expert testimony and granting summary judgment, notwithstanding admissible expert testimony on disputed material facts that should have been submitted to a jury for decision?

While the column by column comparisons found in the Appendix at 132-139 are by no means exhaustive of all the testimony and reports provided by the experts,[7] Petitioner demonstrates with these entries that the lower courts erroneously weighed the admitted expert testimony on Petitioner's burden of proof, against expert testimony proffered by Respondents' experts, thus invading the province of the trier of fact. Moreover, this expert evidence was admitted under applicable law.

If expert testimony was insufficient to overcome summary judgment on standing and injury, as well as on every other point raised on the merits of Petitioner's claims in the district court's decision, nowhere does either the district court, or the appellate court, explain why this testimony failed to create a material fact in dispute. Both decisions also do not indicate any facts that are necessary to state a cause of action but on which the experts produced insufficient evidence. The district court merely opined that the expert testimony was not persuasive. The appellate court concluded that certain facts necessary for standing and injury were unsupported by the evidence, without ever mentioning that admitted expert testimony

[7] Seaman, for example, tendered a 300+ page report with exhibits and was deposed for nearly 12 hours over two days, in Atlanta and in Washington, DC. Minore was similarly deposed for several hours.

existed on those very facts and why it deemed that testimony insufficient.

Summary judgment ended the Petitioner's claim in this matter. Reflection upon the circumstances that anteceded this result, however, should give a sober person pause. Subsequent to an extensive *Daubert* hearing, the district court admitted all of the Petitioner's experts. This expert opinion reached all of the material facts necessary to establish a claim for relief under applicable law. Yet the court ruled that this evidence was not sufficient to survive summary judgment. This ruling was not accompanied by any explanation, by the trial or appellate courts, why admissible expert opinion regarding material facts was not sufficiently probative to create genuine issues of material fact. Instead, the courts below effectively weighed the evidence and, finding it unpersuasive by their lights, directed a finding against the Petitioner. The lower courts erred in this regard, and should have permitted this case to proceed to trial. *See Feltner v. Columbia Pictures Television, Inc.*, 523 U.S. 340 (1998) (recognition of Seventh Amendment right to jury trial).

CONCLUSION

For the reasons stated above, Petitioner, Carolyn G. Kochert, M.D., respectfully requests that this Court grant her Petition for Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit.

Respectfully submitted,

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463 F.3d 710

United States Court of Appeals,
Seventh Circuit.
Carolyn G. **KOCHERT**, Plaintiff-Appellant,
v.
GREATER LAFAYETTE HEALTH SERVICES, INC., et al., Defendants-Appellees.
No. 05-1196.
Argued Feb. 13, 2006.
Decided Sept. 12, 2006.

Rehearing and Rehearing en Banc Denied Oct. 6, 2006.

Miles J. Zaremski (argued), Kamensky Rubinstein Hochman & Delott, LLP, Lincolnwood, IL, for Plaintiff-Appellant.

Larry R. Fisher, Stephen R. Pennell (argued), Stuart & Branigin LLP, Lafayette, IN, *Judy L. Woods* (argued), Bose McKinney & Evans LLP, Indianapolis, IN, for Defendants-Appellees.

Before *KANNE*, *EVANS*, and *WILLIAMS*, Circuit Judges.

WILLIAMS, Circuit Judge.

In this appeal, Carolyn Kochert challenges the district court's grant of summary judgment for the defendants on Kochert's claims alleging violations of Sections 1 and 2 of the Sherman Antitrust Act. Mindful of the Supreme Court's admonition that the purpose of federal antitrust law "is not to protect businesses from the working of the market; it is to protect the public from the failure of the market," *see Spectrum Sports, Inc. v. McQuillan*, 506 U.S. 447, 458, 113 S.Ct. 884, 122 L.Ed.2d 247 (1993), we conclude that Kochert does not have antitrust standing, and so we affirm the judgment of the district court.

I. BACKGROUND

Carolyn Kochert, M.D., began practicing anesthesiology in Lafayette, Indiana in 1985. From 1985 to 1994, Kochert practiced at both of the hospitals in Lafayette, Home Hospital and St. Elizabeth's Medical Center ("SEMC"). In 1994, Home Hospital and defendant Anesthesia Associates entered into a contract granting Anesthesia Associates, an anesthesiology practice group, exclusive rights to provide anesthesia services at Home Hospital. It is undisputed that exclusive services arrangements between anesthesiology practice groups and hospitals are commonplace in this industry and do not inherently raise anticompetitive concerns. After being offered the contract for anesthesia services at Home Hospital, Anesthesia Associates offered anesthesiologists with privileges at Home Hospital subcontracts to provide anesthesia services at Home Hospital. Kochert received a subcontract, which was eventually extended to 1998. Although Kochert's Home Hospital subcontract was not renewed in 1998, she continued to provide anesthesia services at SEMC.

In 1998, Home Hospital and SEMC merged to form defendant Greater Lafayette Health Services ("GLHS"), which administered both hospitals. Soon thereafter, Lafayette Anesthesiologists, a practice group of which Kochert was a member, obtained an exclusive three-year anesthesiology contract at SEMC, in which Kochert participated. When this contract expired in 2001, GLHS did not renew its ties with Lafayette Anesthesiologists and instead contracted with Anesthesia Associates to provide exclusive anesthesia services at SEMC. Anesthesia Associates's contract to provide exclusive anesthesia services at both Home Hospital and SEMC has been extended several

times and the current extension terminates October 14, 2006.

Kochert claims that Lafayette Anesthesiologists was the only group "within an hour of Lafayette" that could provide a competitive check on Anesthesia Associates. Due to Anesthesia Associates's exclusive contracts, Kochert alleges that she has been unable to practice anesthesiology at Home Hospital since March 1998 and at SEMC since 2001. Kochert claims that consumer welfare decreased because of the exclusive contracts with Anesthesia Associates. For instance, she states that before Home Hospital awarded the exclusive contract to Anesthesia Associates in 1994, there were no reported problems with anesthesiologists leaving operating rooms or otherwise failing to monitor patients undergoing surgery, while such problems became commonplace after the grant of the exclusive contract to Anesthesia Associates in 1994. She also claims that the exclusive contracts increased anesthesia services prices and increased delayed surgeries due to the unavailability of Anesthesia Associates anesthesiologists. Defendants counter that short absences of anesthesiologists during surgical procedures is commonplace, and they cite a 1997 report by the American Society of Anesthesiologists that determined the "quality of anesthesia care at Home Hospital to be good."

Allegedly because of the limitations on her anesthesiology practice, Kochert began considering a practice in pain management in 1998. She received board certification in pain management in 1999, and later that year opened a pain management practice (Advanced Pain Management). By August 1, 2000, Kochert was practicing pain management full time. Kochert claims that she did not enter that field voluntarily, but rather was forced into pain

management practice due to the operation of the exclusive Anesthesia Associates contracts. She claims that she made written requests to exercise her privileges in anesthesiology at GLHS in 2002 and 2003. Kochert continues to practice pain management at Home Hospital and SEMC today.

In September 2001, Kochert brought this antitrust suit against GLHS, Anesthesia Associates, and John Walling (GLHS's CEO). She alleged that she suffered antitrust injury as a direct consequence of the defendants' actions excluding competition from the market and that the defendants exercised monopoly power in the market. To support her claims, Kochert attempted to introduce the testimony of several experts, including Dr. Bruce Seaman, an economist. Seaman opined that the relevant product market was "anesthesia services,"[1] and offered three versions of the relevant geographic market,[2] the broadest of which included Tippecanoe County and seven contiguous counties.

Defendants GLHS and Anesthesia Associates filed *Daubert*[3] motions to exclude Seaman's testimony, arguing that Seaman had (1) incorrectly defined the relevant product market, (2) used incorrect methodology in defining

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[1] According to Kochert's brief, the relevant product is "anesthesia services in support of inpatient surgical and obstetrical services, both requiring a hospital stay of greater than 23 hours." (Pl. Brief at 15.) References to "anesthesia services" throughout this opinion are generally limited to this definition.

[2] The three versions offered were (1) Tippecanoe County, (2) Tippecanoe, Montgomery, Clinton and White Counties, and (3) Tippecanoe and its seven contiguous counties.

[3] *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 509 U.S. 579, 113 S.Ct. 2786, 125 L.Ed.2d 469 (1993).

the relevant geographic market and unreliable definitions, and (3) failed to do a dynamic analysis. After extensive hearings and oral arguments regarding the *Daubert* issue, the district court admitted Seaman's expert testimony, noting that the fact that the evidence passed muster under a *Daubert* relevance and reliability analysis did "not ensure or decide whether such evidence is ultimately persuasive." The question of the evidence's persuasiveness, the district court stated, would be decided "either during summary judgment or at trial."

A month later, the district court granted summary judgment to the defendants on all counts and claims. The district court found that Kochert had no antitrust standing and had not met her burden of proving an antitrust violation. The court ruled that Kochert could not withstand summary judgment on the antitrust violation in part because she could not show that the defendants' alleged practices had produced any anti-competitive effects in the relevant geographic market.[4] Specifically, the district court held that Seaman's eight-county geographic market was too narrow for two reasons: the results of his analysis for this area did not yield results sufficient to accept his definition of the market, and Seaman's analysis ignored commercial realities of the area.

The district court also concluded that: (1) Kochert failed to demonstrate that the exclusive contract between GLHS and Anesthesia Associates constituted an unlawful tying arrangement; (2) the contract between Anesthesia Associates and GLHS did not constitute an illegal "group

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[4] *Kochert v. Greater Lafayette Health Servs.*, 372 F.Supp.2d 509, 516 (N.D.Ind.2004).

boycott" of Kochert; (3) no reasonable trier of fact could conclude that the defendants caused actual harm to competition, or that GLHS is able to restrain trade due to its market power; (4) the defendants lacked the requisite specific intent necessary for a conspiracy to monopolize in violation of the Sherman Act; (5) *res judicata* barred Kochert's Count V group boycott claim; (6) Kochert could not succeed on her "essential facility" claim because alternative facilities are available; and (7) Kochert's Indiana state antitrust claims could not survive summary judgment.

Kochert now appeals the grant of summary judgment.

II. ANALYSIS

We review the district court's grant of summary judgment *de novo*. *In re Copper Antitrust Litigation,* 436 F.3d 782, 788 (7th Cir.2006). All facts must be construed in the light most favorable to Kochert, the non-moving party. *Id.* The district court's grant of summary judgment was proper only if there was "no genuine issue as to any material fact and . . . the moving party [was] entitled to a judgment as a matter of law." Fed.R.Civ.P. 56(c); *Celotex Corp. v. Catrett,* 477 U.S. 317, 322-23, 106 S.Ct. 2548, 91 L.Ed.2d 265 (1986).

A. Article III Standing

The defendants argue, for the first time on appeal, that Kochert lacks standing under Article III of the United States Constitution. Of course, defendants are not precluded from raising this claim because such a challenge to the court's jurisdiction may not be waived. *See FW/PBS,*

Inc. v. City of Dallas, 493 U.S. 215, 230-31, 110 S.Ct. 596, 107 L.Ed.2d 603 (1990). Indeed, we "are under an independent obligation to examine [our] own jurisdiction, and standing 'is perhaps the most important of the jurisdictional doctrines.'" *Id.* (quoting *Allen v. Wright,* 468 U.S. 737, 750, 104 S.Ct. 3315, 82 L.Ed.2d 556, (1984)) (brackets omitted). Generally, all that is required to demonstrate Article III standing is "injury in fact plus redressability." *See U.S. Gypsum Co. v. Indiana Gas Co., Inc.,* 350 F.3d 623, 627 (7th Cir.2003); *Sanner v. Bd. of Trade of City of Chicago,* 62 F.3d 918, 922 (7th Cir.1995) (stating with more specificity that "(1) the party must personally have suffered an actual or threatened injury caused by the defendant's allegedly illegal conduct, (2) the injury must be fairly traceable to the defendant's challenged conduct, and (3) the injury must be one that is likely to be redressed through a favorable decision") (quoting *Valley Forge Christian Coll. v. Americans United for Separation of Church and State,* 454 U.S. 464, 472, 102 S.Ct. 752, 70 L.Ed.2d 700 (1982)).

The defendants argue that Kochert cannot demonstrate that her injury is "fairly traceable" to their challenged conduct, and cite our *Sanner* decision, where we concluded that "soybean farmers who refrained from selling soybeans due to the depressed price of the cash market lack[ed] standing under Article III" to pursue their antitrust claims. *See Sanner,* 62 F.3d at 923. We reasoned in *Sanner* that these farmers could not establish the traceability prong of the Article III standing inquiry because the decision not to sell could have been motivated by many factors and it would be impossible to weigh the impact of the alleged violation on this omission. *See id.* at 923. Defendants analogize this to Kochert's situation by

arguing that she is incapable of demonstrating that her decision to exit the anesthesia services market was the exclusive product of their anticompetitive actions. They point to the timing of her exit from the anesthesia services market and portions of her deposition testimony suggesting that other considerations may have played a role.

We do not agree that Kochert lacks Article III standing. As discussed *infra,* the defendants have raised a significant challenge to Kochert's antitrust standing. But the Article III standing inquiry does not require Kochert to prove as much. *See, e.g., Florida Seed Co., Inc. v. Monsanto Co.,* 105 F.3d 1372, 1374 (11th Cir.1997) ("Antitrust standing requires more than the 'injury in fact' and the 'case or controversy' required by Article III of the Constitution."). A question of material fact remains as to whether Kochert suffered an injury as a result of defendants' actions since Kochert can construct a reasonable causality chain linking her injury to defendants' actions. What remains in question is whether any of defendants' actions were anticompetitive and, if so, whether the *anticompetitive actions* led to Kochert's injury. We think it more appropriate to assess these questions in the context of antitrust standing and antitrust injury.

B. Antitrust Standing and Injury

The Supreme Court has observed that "[a]ntitrust laws in general, and the Sherman Act in particular, are the Magna Carta of free enterprise .... as important to the preservation of economic freedom and our free-enterprise system as the Bill of Rights is to the protection of our fundamental personal freedoms." *United States v. Topco Associates, Inc.,* 405 U.S. 596, 610, 92 S.Ct. 1126, 31

L.Ed.2d 515 (1972). Section 1 of the Sherman Act provides that "[e]very contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is declared to be illegal." 15 U.S.C. § 1. The purpose of the Act is "to assure customers the benefits of price competition." *See Associated Gen. Contractors of Cal., Inc. v. Cal. State Council of Carpenters, et al.,* 459 U.S. 519, 538, 103 S.Ct. 897, 74 L.Ed.2d 723 (1983) (discussing the legislative history). The Supreme Court has stated that the "central interest" of the Act is "protecting the economic freedom of participants in the relevant market." *Id.* We have similarly observed that "[t]he principal purpose of the antitrust laws is to prevent overcharges to consumers." *Premier Elec. Constr. Co. v. Nat'l Elec. Contractors Ass'n, Inc.,* 814 F.2d 358, 368 (7th Cir.1987).

Given the intent of our antitrust laws, courts have developed the doctrine of "antitrust standing" and the subsidiary doctrine of "antitrust injury" in order to assure efficient use of the resources of the courts towards achieving these goals. *See generally* William H. Page, *The Scope of Liability for Antitrust Violations,* 37 STAN. L. REV. 1445, 1446-63 (1985); *see also U.S. Gypsum Co. v. Indiana Gas Co., Inc.,* 350 F.3d 623, 627 (7th Cir.2003) (questioning the wisdom of the "antitrust standing" nomenclature in light of the potential for confusion with Article III standing). Under Section 4 of the Clayton Act, "any person who shall be injured in his business or property by reason of anything forbidden in the antitrust laws may sue therefor in any district court of the United States in the district in which the defendant resides or is found or has an agent." 15 U.S.C. § 15(a). The Supreme Court has cautioned that this seemingly broad language must be interpreted more

narrowly in light of Congressional intent as revealed by the legislative history. *See Associated Gen. Contractors,* 459 U.S. at 529-35, 103 S.Ct. 897. Thus, "not all persons who have suffered an injury flowing from [an] antitrust violation have standing to sue under § 4." *In re Industrial Gas Antitrust Litigation,* 681 F.2d 514, 516 (7th Cir.1982). Under our precedent, "only those parties who can most efficiently vindicate the purposes of the antitrust laws have antitrust standing to maintain a private action under § 4." *Serfecz v. Jewel Food Stores,* 67 F.3d 591, 597-98 (7th Cir.1995) (quoting *In re Industrial Gas,* 681 F.2d at 516). Kochert must demonstrate that she meets the requirements of both antitrust injury and antitrust standing to succeed on the merits of her tying, boycott, and conspiracy claims under the Sherman Act. *See Greater Rockford Energy and Technology Corp. v. Shell Oil Co.,* 998 F.2d 391, 404 (7th Cir.1993) ("a showing of both antitrust injury and antitrust standing are necessary to proceed under § 4").

1. Antitrust Injury

The threshold question for our inquiry is whether Kochert has suffered an antitrust injury. Kochert must demonstrate that her "claimed injuries are 'of the type the antitrust laws were intended to prevent' and 'reflect the anticompetitive effect of either the violation or of anticompetitive acts made possible by the violation.'" *Tri-Gen Inc. v. Int'l Union of Operating Eng'rs, Local 150,* 433 F.3d 1024, 1031 (7th Cir.2006) (quoting *Brunswick Corp. v. Pueblo Bowl-O-Mat, Inc.,* 429 U.S. 477, 489, 97 S.Ct. 690, 50 L.Ed.2d 701 (1977)). Kochert's cognizable injuries are variations on the theme of lost income in her anesthesia practice. We must determine whether these alleged

injuries are the result of defendants' allegedly anticompetitive acts.

But first, we must assess what anticompetitive behavior is at stake here. The parties dispute the starting point of defendants' anticompetitive acts. The most obvious point in time is 2001, when GLHS formulated its exclusive contract with Anesthesia Associates. Before this point, Lafayette Anesthesiologists had an exclusive contract with SEMC while Anesthesia Associates had an exclusive contract at Home Hospital, and, therefore, the Lafayette market was serviced by two competing anesthesia services groups. Only after GLHS contracted exclusively with Anesthesia Associates in 2001 were the doctors of Lafayette Anesthesiologists (and hence Kochert) completely foreclosed from practicing anesthesia services at either of the two Lafayette Hospitals. This time line creates an obvious problem for Kochert because the record makes clear that she was no longer a practicing anesthesiologist at this point.[5]

Recognizing this problem, Kochert argues that the real starting point of defendants' anticompetitive acts is 1998, when Anesthesia Associates declined to renew its subcontract with her. Kochert's theory is that this event set off an anticompetitive chain reaction which culminated in her complete exclusion from the Lafayette anesthesia services market in 2001. Kochert does not contend that the pre-2001 activity, viewed independently, constituted anticompetitive activity under the Sherman Act. Indeed,

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[5] Kochert has maintained anesthesia privileges at SEMC, but the record is clear that she was practicing pain management full-time by mid-2000.

her expert, Seaman, testified at his deposition that the events in Kochert's chain prior to 2001 did not independently raise "any major anticompetitive concern." The only independent event Seaman identified as having anticompetitive effects was GLHS's 2001 discontinuation of the exclusive contract between SEMC and Lafayette Anesthesiologists. Seaman, however, also advanced Kochert's chain reaction theory of anticompetitive effects.

We agree with the district court that Kochert's chain reaction theory must be rejected. Kochert has offered no precedential support for the proposition that a court should look backward from the point of the actual anticompetitive activity in search of the genesis of the acts that eventually allowed the anticompetitive behavior to occur. Such an examination would have no logical starting point in this case. Kochert argues for 1998, which coincides with the point at which her injuries accrued, but one could just as easily argue that the starting point of the chain reaction was 1994, when Home Hospital first awarded an exclusive contract to Anesthesia Associates. But the 1994 contracting is not logically the first domino because it clearly was not part of an anticompetitive scheme. The same logic applies to the 1998 denial of renewal of Kochert's subcontract – either this act constituted a part of an anticompetitive scheme or it did not. If it did not, it is not the starting point for our examination of defendants' allegedly anticompetitive behavior.

Kochert asserts that events in an antitrust case must be viewed "not in a vacuum or in isolation, but as a continuum," and cites several cases in support of this contention, including our decision in *In re High Fructose Corn Syrup Antitrust Litigation,* 295 F.3d 651, 655-56 (7th Cir.2002). We do not quibble with the proposition that

courts should not be myopic in their assessment of potential violations of the antitrust laws, but Kochert's reliance on this concept is misplaced in the context of the current inquiry. If she could demonstrate that the events of 1998 actually were elements of a broader anticompetitive scheme, we would be remiss if we failed to consider them in the antitrust injury assessment. But she cannot. There is no evidence that any of the events of 1998, including Anesthesia Associates's decision to deny Kochert a subcontract, were part of an anticompetitive scheme that culminated with GLHS's decision to contract exclusively with Anesthesia Associates. They were simply staffing decisions made solely by parties without market control. We have stated explicitly that "the staffing decision at a single hospital [is] not a violation of section 1 of the Sherman Act." *See BCB Anesthesia Care Ltd. v. Passavant Memorial Area Hospital Ass'n,* 36 F.3d 664, 668 (7th Cir.1994) (collecting cases).

Furthermore, the cases Kochert cites in support of her argument do not address the issue of antitrust injury as we examine it here. *In re High Fructose* discusses the need for holistic examination of a defendant's acts in the context of a court's assessment of price-fixing arrangements. *See In re High Fructose,* 295 F.3d at 655 ("The second trap to be avoided in evaluating evidence of an antitrust conspiracy for purposes of ruling on the defendants' motion for summary judgment is to suppose that if no single item of evidence presented by the plaintiff points unequivocally to conspiracy, the evidence as a whole cannot defeat summary judgment"). The case does not address either antitrust standing or antitrust injury. The other cases cited by Kochert are similarly inapposite. *See Continental Ore Co. v. Union Carbide & Carbon Corp.,* 370 U.S. 690, 699, 82

S.Ct. 1404, 8 L.Ed.2d 777 (1962) ("(T)he character and effect of a conspiracy are not to be judged by dismembering it and viewing its separate parts, but only by looking at it as a whole.") (quoting *American Tobacco v. United States,* 147 F.2d 93, 106 (6th Cir.1945)); *Aspen Highlands v. Aspen Skiing Co.,* 738 F.2d 1509, 1522 n. 18 (10th Cir.1984) (concluding that the six parts of the plaintiff's evidence of monopolization "should be viewed as a whole."); *City of Mishawaka, et al. v. American Elec. Power Co.,* 616 F.2d 976, 986 (7th Cir.1980) (concluding that the various acts of a monopoly in a "price squeezing" scheme can not be looked at in a vacuum for the purposes of determining whether there is evidence of a Sherman Act violation). Moreover, none of the plaintiffs in the cases Kochert cites attempted to introduce evidence of activity postdating their participation in the market as proof of antitrust injury. Kochert has not introduced evidence supporting the conclusion that anything other than GLHS's 2001 elimination of the exclusive contract between SEMC and Lafayette Anesthesiologists should be considered as the starting point for our antitrust injury analysis.

This conclusion brings into focus the central question in assessing Kochert's alleged antitrust injury: did GLHS's 2001 elimination of the exclusive contract between SEMC and Lafayette Anesthesiologists cause Kochert's injuries? Put another way, was this act "the cause-in-fact of the injury," or can it be said that "'but for' the violation, the injury would not have occurred"? *See Greater Rockford Energy and Technology Corp. v. Shell Oil Co.,* 998 F.2d 391, 395 (7th Cir.1993). Since Kochert was practicing pain management full-time as of August 2000, the answer to all of these questions is "no." GLHS's anticompetitive behavior in 2001 did not injure Kochert's anesthesiology practice

because it was nonexistent by this point. Kochert therefore fails to establish one necessary prong of the two-pronged test that the Supreme Court described in *Brunswick Corp.*; she cannot demonstrate that her injuries "flow[] from that which makes defendants' acts unlawful." *Brunswick Corp.*, 429 U.S. at 489, 97 S.Ct. 690. She has not demonstrated antitrust injury.

2. Antitrust Standing

Even if Kochert could establish antitrust injury, she would still fail to establish antitrust standing because she is not the party "who can most efficiently vindicate the purposes of the antitrust laws" in this case. *See Serfecz*, 67 F.3d at 598. The Supreme Court has identified six factors that courts should weigh in making this assessment:

> (1) [t]he causal connection between the alleged anti-trust violation and the harm to the plaintiff; (2) [i]mproper motive; (3) [w]hether the injury was of a type that Congress sought to redress with the antitrust laws; (4) [t]he directness between the injury and the market restraint; (5) [t]he speculative nature of the damages; (6) [t]he risk of duplicate recoveries or complex damages apportionment.

Sanner, 62 F.3d at 927 (describing factors articulated in *Associated General Contractors*, 459 U.S. at 537-46, 103 S.Ct. 897).

The fourth factor weighs particularly heavily in this case. In discussing the directness inquiry, the Supreme Court stated that "[t]he existence of an identifiable class of persons whose self-interest would normally motivate them to vindicate the public interest in antitrust enforcement

diminishes the justification for allowing a more remote party . . . to perform the office of a private attorney general." *Associated Gen. Contractors,* 459 U.S. at 542, 103 S.Ct. 897.

As was the case in *Serfecz,* Lafayette's anesthesia "consumers could maintain an action if defendants' actions stifled competition allowing defendants to engage in monopoly pricing in the retail [] market." *See Serfecz,* 67 F.3d at 598. These consumers, or perhaps one of the entities that is also directly affected by rises in anesthesia services prices, such as an insurer, would be a more efficient claimant. The Court's concern with opening the antitrust litigation floodgates also suggests that groups of doctors, such as the excluded Lafayette Anesthesiologists group, might serve as better plaintiffs than individual doctors like Kochert. Denying Kochert "a remedy on the basis of its allegations in this case is not likely to leave a significant antitrust violation undetected or unremedied." *See Associated Gen. Contractors,* 459 U.S. at 542, 103 S.Ct. 897. If Anesthesia Associates and GLHS are truly manipulating the anesthesia services market in order to raise prices and drive down quality of care, these effects will not be missed by patient-consumers or insurers.

Two other factors outlined in *Associated General Contractors* that weigh against a finding of antitrust standing are addressed in the context of our antitrust injury analysis. Though Kochert is arguably a direct competitor, the causal connection between her injury and the antitrust violation is tenuous at best. Kochert has also failed to produce evidence of improper motive. She has not offered any arguments with regard to the other factors sufficient to tip the scales away from our ultimate conclusion. Kochert does not have antitrust standing.

Finally, though it is ultimately unnecessary, we note that the record is bereft of any credible evidence of the type of anticompetitive effects alleged by Kochert. Kochert's economics expert testified at his deposition that "there is no particular evidence on nominal rates that would suggest an exercise in market power." With no evidence that prices, in the normal sense, have been affected by anticompetitive activity, Kochert (and her expert) relied exclusively on her evidence of diminished quality of care as proof of anticompetitive effect, in and of itself, and as proof of higher "quality adjusted" costs. But no reasonable jury, examining Kochert's evidence of diminished quality, could find it credible as proof of such diminution. Kochert has not introduced any evidence that would allow a jury to compare the quality of care prior to defendants' anticompetitive acts with the quality of care after these acts. She has not introduced any statistical analysis focusing on measurable indices of quality, such as the number of patient complaints or mortality rates. Instead, Kochert offers expert testimony and physician affidavits which rely almost exclusively on anecdotes, such as one story about an anesthesiologist leaving an operating room momentarily to eat a sandwich, to prove diminished quality. We have serious doubts about the usefulness of Kochert's evidence. But we will not resolve this issue because it is clear that Kochert does not have antitrust standing.

III. CONCLUSION

The judgment of the district court is AFFIRMED.

372 F.Supp.2d 509

United States District Court,
N.D. Indiana,
Hammond Division.
Carolyn G. KOCHERT, M.D., Plaintiff,
v.
GREATER LAFAYETTE HEALTH SERVICES, INC.,
d/b/a St. Elizabeth Medical Center and
d/b/a Lafayette Home Hospital,
Anesthesiology Associates, P.C., and
John Walling, Defendants.
No. 4:01CV0027 AS.
Dec. 29, 2004.

Michael B. Brohman, Miles J. Zaremski, Ron S. Brand, Lincolnwood, IL; Randall L. Vonderheide, Lafayette, Robert P. Kinsella, Schererville, IN, for Plaintiff.

Larry R. Fisher, Stephen R. Pennell, Lafayette, IN; Andrew M. McNeil, Beth L. Riga, Judy L. Woods, Ronald E. Elberger, Indianapolis, IN, for Defendant.

MEMORANDUM AND ORDER

ALLEN SHARP, District Judge.

On September 18, 2001, Plaintiff Dr. Carolyn Kochert, M.D., filed an amended complaint in this Court alleging various antitrust violations under both federal and state laws. On April 30, 2004, Defendant Greater Lafayette Health Services, Inc. ("GLHS") filed a Motion for Summary Judgment pursuant to Rule 56(a) of the Federal Rules of Civil Procedure. On that same day, Defendant Anesthesiology Associates, P.C. ("AA") filed its own motion for Summary Judgment.

This case has now been pending in this Court since 2001 and, in spite of Plaintiff's counsels' protestations to

the contrary, a massive discovery effort has advanced. It is obviously the serious burden of this Court to look very carefully under Rule 56 at this record. This case has received abundant attention from this Court, including the highly qualified assistance of a United States Magistrate Judge. This Court conducted extensive proceedings in October, 2004 and entered a series of evidentiary rulings, including several challenges to expert witnesses under the Daubert standard, on or about November 15, 2004. This Court also heard oral arguments on these Motions for Summary Judgment in South Bend, Indiana for a period of over two hours on November 26, 2004.

While listening to those arguments, especially of the ones for the Plaintiff, this court could not escape the impression that either a contract case, due process case, or employment discrimination case, was being argued. The plain fact is that this case is none of the above. It is absolutely essential to revisit first principals regarding Antitrust requirements here.

When it is all said and done, and in spite of the best efforts of very able counsel, this Plaintiff has simply failed to present a jury issue under the Seventh Amendment in regards to her claims of Antitrust violation.

This Court is also aware that the bundle of rulings entered on November 15, 2004 include some limited exclusions of evidence which remain binding on the parties and which are followed here. Though the Court expressed judgments on the reliability and methodology of expert witness testimony, it did not pass judgment on whether those opinions were persuasive or sufficient to create a genuine issue of material fact.

Finally, this Court is compelled to give serious notice as background and otherwise to earlier litigation spawned by Kochert in both state and federal courts. Kochert filed her first federal lawsuit in this Court in 1998 in Cause Number 4:98CV0053. She filed a complaint in the Tippecanoe Circuit Court, under Cause No. 79C01-0001-CP-0007, in January 2000. In both cases, Kochert sought to recover damages from the Defendants on various theories arising out of contract disputes with AA. In both the 1998 federal court case and the 2000 state court case, Kochert's claims against the hospital were dismissed on summary judgment.

BACKGROUND

The Plaintiff, Carolyn Kochert, M.D., first began practicing anesthesiology in Lafayette, Indiana in 1985. From 1985 to 1994, Kochert practiced anesthesia at both Lafayette Home Hospital ("HH") and St. Elizabeth's Medical Center ("SEMC"). On August 9, 1994, Defendant Anesthesia Associates ("AA") and HH entered into a contract for AA to be the exclusive provider of anesthesia services at HH. After being offered the exclusive services contract for anesthesia services at HH, AA offered each anesthesiologist with current privileges at HH a subcontract to provide anesthesia services at HH. Kochert was given such a subcontract. At some point during 1998, AA's Board of Directors voted not to renew Kochert's subcontract with AA after its expiration in February 1998. In 1998, HH and SEMC merged and GLHS took over administration of both hospitals at the end of that year. In April 1999, the labor and delivery unit at SEMC was closed. At the beginning of 2001, GLHS contracted with AA to

provide anesthesia services at SEMC beginning on June 1, 2001.

STANDARD OF REVIEW

Summary judgment is proper if the pleadings, depositions, answers to interrogatories and admissions on file, together with any affidavits, show that there exists no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law. Fed.R.Civ.P. 56(c); *Celotex Corp. v. Catrett,* 477 U.S. 317, 106 S.Ct. 2548, 91 L.Ed.2d 265 (1986); *Anderson v. Liberty Lobby, Inc.,* 477 U.S. 242, 106 S.Ct. 2505, 91 L.Ed.2d 202 (1986); *Bragg v. Navistar Int'l Trans. Corp.,* 164 F.3d 373 (7th Cir.1998). *Celotex* addressed the initial burdens of the parties under Rule 56, and *Anderson* addressed the standards under which the record is to be analyzed within the structure of Rule 56.

The initial burden is on the moving party to demonstrate, "with or without supporting affidavits," the absence of a genuine issue of material fact and that judgment as a matter of law should be granted in the moving party's favor. *Celotex,* 477 U.S. at 324, 106 S.Ct. 2548 (quoting Fed.R.Civ.P. 56); *Larimer v. Dayton Hudson Corp.,* 137 F.3d 497 (7th Cir.1998). A question of material fact is a question which will be outcome determinative of an issue in the case. The Supreme Court has instructed that the facts material in a specific case shall be determined by the substantive law controlling the given case or issue. *Anderson,* 477 U.S. at 248, 106 S.Ct. 2505. Once the moving party has met the initial burden, the opposing party must "go beyond the pleadings" and "designate 'specific facts shows that there is a genuine [material] issue for trial.'"

Id. The nonmoving party cannot rest on its pleadings, *Weicherding v. Riegel,* 160 F.3d 1139 (7th Cir.1998); *Waldridge v. American Hoechst Corp.,* 24 F.3d 918 (7th Cir.1994); nor may that party rely upon conclusory allegations in affidavits. *Smith v. Shawnee Library Sys.,* 60 F.3d 317, 320 (7th Cir.1995).

During its summary judgment analysis, the court must construe the facts and draw all reasonable inferences in the light most favorable to the nonmoving party. *Bombard v. Fort Wayne Newspapers, Inc.,* 92 F.3d 560 (7th Cir.1996). Furthermore, it is required to analyze summary judgment motions under the standard of proof relevant to the case or issue. *Anderson,* 477 U.S. at 252-55, 106 S.Ct. 2505. Applying the above standard, this Court will now address the present motions.

DISCUSSION

I. ANTITRUST STANDING

Kochert seeks to recover damages under Section 4 of the Clayton Act, for alleged violations of Section 1 and 2 of the Sherman Antitrust Act. Both antitrust injury and standing are necessary to proceed under Section 4. *Greater Rockford Energy and Technology Corp. v. Shell Oil Co.,* 998 F.2d 391, 395 (7th Cir.1993). "It is now well settled that in order to have standing to prosecute private antitrust claims, plaintiffs must show more than the defendants' conduct caused them an injury." *Balaklaw v. Lovell,* 14 F.3d 793, 797 (2d Cir.1994). Instead, "[p]laintiffs must prove an antitrust injury, which is to say injury of the type the antitrust laws were intended to prevent and that flows from that which makes defendant's acts unlawful." *Id.; accord Indiana Grocery v. Super Valu Stores, Inc.,* 864 F.2d

1409, 1416 (7th Cir.1989). Kochert has not suffered an antitrust injury and therefore she does not have antitrust standing.

Kochert has conceded that the non-renewal of her contract in 1998 did not cause her to sustain any antitrust injury. Kochert Memo. in Opposition to Defendants' Rule 12 Motions to Dismiss at p. 35. Instead, Kochert contends that there was "a sequence of events that, when combined, creates anti-competitive concerns that might not have been present had those three events not been combined." Kochert Brief p. 7. Kochert contends that a combination of the nonrenewal of her subcontract by AA, the consolidation of the OB unit at SEMC with the OB unit at HH in April 1999, and awarding the exclusive contract to SEMC to AA in June 2001 form the basis of her antitrust claim. Kochert was no longer in the business of providing anesthesia services by June 1, 2001, however. Kochert had opened her own pain management practice and was doing pain management on a full time basis by August 1, 2000. Therefore, Kochert could not have sustained any antitrust injury which was caused by GLHS's decision to award the exclusive contract at SEMC to AA in June 2001. *See Reddy v. Good Samaritan Hosp. & Health Ctr.,* 137 F.Supp.2d 948, 967 (S.D.Ohio 2000). This fact is confirmed by Kochert's damages expert, Hoffman, who determined that all of Kochert's damages were caused by the nonrenewal of her subcontract with AA in 1998.

Furthermore, Kochert fails to establish an antitrust injury because the injury alleged was not the type of injury the antitrust laws were intended to prevent. To sustain an antitrust injury there must be more than mere harm to a competitor. Rather, there must be harm to competition. The Supreme Court has stated that the

plaintiff's injury must be "an injury caused by anti-competitive behavior as opposed to mere economic loss." *Brunswick Corp. v. Pueblo Bowl-O-Mat, Inc.*, 429 U.S. 477, 488-89, 97 S.Ct. 690, 50 L.Ed.2d 701 (1977). Kochert's alleged injuries are to her as a competitor, not injuries to competition.

Kochert is unable to show direct anticompetitive effects on the price, quantity or quality of anesthesia services caused by the defendants. To show an antitrust injury, Kochert must prove that the exclusive contract affected the price, quantity or quality of anesthesia services, not just her own welfare. *Davies v. Genesis Med. Ctr.*, 994 F.Supp. 1078, 1093 (S.D.Iowa 1998) The harm Kochert alleges, working more hours at SEMC and changing her specialty, is indirect and cannot be tied directly to the alleged anticompetitive acts or their effects – raising anesthesia prices and diminishing anesthesia services. Kochert did not pay for anesthesia services and was not a provider of anesthesia services at all relevant times. Thus, Kochert has not shown that she was harmed in any way by any anticompetitive effect on the price, quantity or quality of anesthesia services, even if these effects are assumed to exist.

II. KOCHERT'S TYING CLAIMS

Kochert alleges in Counts I and II of her complaint that the exclusive contract between GLHS and AA constitutes an unlawful tying arrangement which is both a per se violation of Section 1 of the Sherman Antitrust Act as well as an unreasonable restraint of trade under the rule of reason.

Kochert's allegations of a per se violation cannot survive summary judgment. This Court finds the decision of *Jefferson Parish Hospital District No. 2 v. Hyde,* 466 U.S. 2, 104 S.Ct. 1551, 80 L.Ed.2d 2, (1984) instructive on this issue. In *Jefferson Parish,* the Court concluded that a per se condemnation of exclusive anesthesia service agreements is appropriate only if there was evidence of forcing a purchaser to do something he would not otherwise do. *Id.* at 15, 104 S.Ct. 1551. Patients are not forced to purchase anesthesia services they would otherwise forego when having surgery or delivering a baby. Thus, Kochert's reliance on a per se analysis is misplaced.

Kochert's claims under the rule of reason are also deficient. In *Carl Sandburg Village Condominium Association No. 1 v. First Condominium Development Co.,* 758 F.2d 203, 207-210 (7th Cir.1985), the Seventh Circuit held that an illegal tying arrangement would not be found where the alleged tying company has no economic interest in the sales of the tied seller.[1] AA billed its patients separately for AA's services. GLHS did not receive fees generated by AA. Any economic benefits which GLHS may have received from having exclusive contracts with AA would be indirect.[2] Therefore, Kochert's illegal tying claims must fail.

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[1] This rule applies with equal force to a per se violation analysis. *Carl Sandburg,* 758 F.2d at 207-210.

[2] Kochert claims that GLHS billed its patients directly for anesthesia services and derived a profit from such services. Deriving a profit from the sale of supplies related to anesthesia services does not create the requisite economic interest. Eberle dep. pp. 216-226.

III. SHERMAN ACT CLAIMS

A. Group Boycott Claims

In Counts III and VIII, Kochert alleges that AA/GLHS contracts constitute a group boycott of her. Group boycotts are illegal only if used to enforce agreements that are themselves illegal. *Collins v. Associated Pathologists, Ltd.* 844 F.2d 473, 479 (7th Cir.1988) (citing *Marrese v. American Academy of Orthopaedic Surgeons,* 726 F.2d 1150, 1155 (7th Cir.1984)) en banc (rev. on other grounds, 470 U.S. 373, 105 S.Ct. 1327, 84 L.Ed.2d 274 (1985)). An exclusive contract between a hospital and a group of physicians to provide professional services is not illegal per se. *Collins,* 844 F.2d at 479-80. Such exclusive contracts amount to nothing more than a decision by a customer to enter into an exclusive dealing agreement with a supplier, even though the supplier's competitors are "foreclosed" from that customer for the life of the contract. *Minnesota Association of Nurse Anesthetists v. Unity Hospital,* 208 F.3d 655, 659-60 (8th Cir.2000). Indeed, every decision to purchase goods or services results in winners and losers as the decision to buy always excludes other potential suppliers. "It is perfectly permissible under the Sherman Act for one business entity to refuse to deal with another business entity." *McMorris v. Williamsport Hospital,* 597 F.Supp. 899, 912 (M.D.Pa.1984).

B. Sherman Act Section 1 Claims Based Upon Unreasonable Restraint of Trade

To meet her initial burden of proving an antitrust violation under the rule of reason in a Section 1 claim, Kochert must show that the alleged antitrust violation has produced anti-competitive effects within the relevant

product and geographic areas. This can be done in two ways. First, a plaintiff may delineate a relevant market and show that the defendant has enough market power to significantly harm competition. Second a plaintiff may demonstrate that the challenged practice has actually produced negative anti-competitive effects. *FTC v. Indiana Federation of Dentists,* 476 U.S. 447, 460-61, 106 S.Ct. 2009, 90 L.Ed.2d 445 (1986). *Minnesota Association of Nurse Anesthetists v. Unity Hospital,* 5 F. Supp 2d. 694, 706, 707 (1998). Kochert has failed to create a genuine issue of material fact as to whether the defendants caused any actual harm to competition, or whether GLHS has sufficient market power to restrain trade in any relevant product or geographic market.

Kochert has failed to demonstrate that an exercise of market power has caused harm to competition through an increase in the price of anesthesia services. There is no evidence to suggest that anesthesia prices involved in this case have increased beyond those in Lafayette and other parts of Indiana. Kochert's own expert, Dr. Seaman, concedes that there is "no particular evidence of nominal rates that would suggest an exercise of market power." Seaman dep. p. 60. Seaman instead suggests that a decrease in quality may have had an effect on the real price, which he defines as price adjusted for quality. Seaman pp. 50-51. Therefore, Kochert must be able to show a decrease in the quality of care that occurred after the exercise of market power. This Kochert has failed to do. She makes much of incidents which she claims demonstrate a reduction in the quality of care, but fails to show that those incidents did not occur or were less prevalent before the exercise of market power. *See Minnesota Association of Nurse Anesthetists,* 5 F.Supp.2d at 707. Even if

Kochert could somehow show that the quality of care is substandard, she must still show that this reduction has occurred as a result of anti-competitive behavior. Furthermore, Kochert has failed to show that there has been actual harm to competition from a reduction in quality because patients were able to choose other hospitals and anesthesiologists within the area. *See Flegel v. Christian Hospital,* 4 F.3d 682, 688-89 (8th Cir.1993) (citing *Jefferson Parish Hospital v. Hyde,* 466 U.S. 2, 29-30, 104 S.Ct. 1551, 80 L.Ed.2d 2 (1984)).

Because Kochert failed to show actual detrimental effects, she must demonstrate that the Defendants have market power within a well-defined relevant market. To show that a defendant has sufficient market power to harm competition, a plaintiff must first define the relevant product and geographic markets affected by the alleged uncompetitive activity.[3]

In defining the relevant geographic market, Kochert's expert on markets, Dr. Seaman, based his analysis on the Elzingha-Hogerty test ("E-H test"). This test calculates a LIFO, a percentage of patients who come from within the geographic area who go to GLHS, as well as LOFI, the percentage of patients from outside the geographic area who go to GLHS. The E-H test. The E-H test is used to determine whether a hypothetical geographic market is self-contained.

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[3] The parties devote much time and energy to disputing the proper relevant product market. Even if the relevant product market is defined as anesthesia services, rather than anesthesiologists, Kochert has failed to adequately define the relevant geographic market involved, and therefore her claim cannot survive summary judgment on this point.

It seems clear that the relevant geographic market cannot be defined as narrowly as Tippecanoe County, which would leave HH and SEMC as the only hospitals in the geographic market. As noted by the Seventh Circuit in *Dos Santos v. Columbus-Cuneo-Cabrini Medical Ctr.,* 684 F.2d 1346, 1353 (7th Cir.1982) and *BCB Anesthesia Care Ltd. v. Passavant Memorial Area Hospital Association,* 36 F.3d 664, 668 (7th Cir.1994) (stating, there is "reason to doubt whether the relevant market can be sliced so small as to embrace only a single hospital"). As Judge Posner stated in *Blue Cross & Blue Shield United of Wisconsin v. Marshfield Clinic,* 65 F.3d 1406, 1412 (7th Cir.1995), "[i]f an entire county has only 12 physicians, one can hardly expect or want them to set up competition with each other." 65 F.3d at 1412

According to Kochert's expert, Dr. Seaman, the relevant geographic market would include Tippecanoe County and the seven counties surrounding Tippecanoe County. Seaman dep. pp. 226-228. This Court finds that Kochert's attempt to define the geographic market as Tippecanoe and the surrounding counties defines the market too narrowly for two reasons.

First, Kochert attempts to average the LIFO and LOFI to reach a combined figure of 80%. Even if this averaging approach is accepted, there is no judicial precedent identified by Kochert that would allow this Court to accept a geographic market based upon a LIFO, or LOFI, or combination thereof of only 80%. *See State of California v. Sutter Health System,* 130 F.Supp.2d 1109, 1123 (N.D.Cal.2001) (LIFO and LOFI of 85% found to be insufficient); *Gordon v. Lewistown Hospital,* 272 F.Supp.2d 393,

428 (M.D.Pa.2003) (Court rejected geographic market based on LOFI of 84% and LIFO of 77.8%).[4]

Second, Kochert's analysis of the geographic market ignores the commercial realities of the Lafayette, Indiana area. A central question in determining a geographic market is "where does a potential buyer look for potential suppliers of the service – what is the geographical area in which the buyer has, or, in the absence of monopoly, would have, a real choice as to price and alternative services?" *United States v. Grinnell Corp.,* 384 U.S. at 588-89, 86 S.Ct. 1698; *Marshfield Clinic,* 65 F.3d at 1410. The geographic market is determined by the commercial realities faced by consumers. *Eastman Kodak Co. v. Image Tech. Servs., Inc.,* 504 U.S. 451, 452-56, 112 S.Ct. 2072, 119 L.Ed.2d 265 (1992). Kochert's proposed geographic market includes portions of counties where residents would be required to drive an hour or more to reach Lafayette. At the same time, Kochert excluded hospitals in Logansport and Lebanon, which are roughly 45 minute drives to Lafayette, as well as hospitals in Rensselaer, Kokomo, Tipton, and Indianapolis which are only about an hour drive from Lafayette. Seaman's own data shows that a significant number of patients living within his proposed eight county area travel to other hospitals outside the area

[4] Kochert will no doubt make much of the fact that Seaman's testimony was deemed by this Court, in the context of a *Daubert* challenge, to be reliable. When that ruling was made, however, the methodology employed by Seaman and its reliability was at issue, not the results of his tests. The Order allowing Seaman's testimony, issued on or about November 15, 2004, was explicit in stating that courts have rejected LIFO and LOFI measurements similar to those offered by Kochert, while at the same time finding those expert opinions at least sufficiently reliable to warrant the courts' consideration.

as almost 24% of the persons living in Tippecanoe, Montgomery and Clinton Counties already go to hospitals in Marion County for hospital services.[5] At the end of the day, Kochert's market analysis and the economic realities of the area simply do not add up to create a sufficient antitrust claim on this issue.

If a plaintiff has successfully met her initial burden under the traditional rule of reason, the burden then shifts to the defendant to show that the GLHS contract promotes a sufficiently pro-competitive objective. *United States v. Brown University,* 5 F.3d 658, 669 (3rd Cir.1993). Even if Kochert successfully satisfied her initial burden, GLHS has demonstrated that its actions served a pro-competitive objective. The evidence demonstrates that GLHS' decision to consolidate the OB unit at SEMC with the OB unit at HH was done for legitimate business purposes to improve efficiencies, reduce costs, and improve quality of care. The number of deliveries at HH and SEMC in 1997 and 1998 led to an underutilization of the facilities and staff at those hospitals. GLHS has realized a substantial savings as a result of this consolidation.

IV. Conspiracy to Monopolize

Kochert alleges in Count IV that AA and GLHS conspired to grant AA a monopoly in the provision of hospital surgical and obstetric anesthesia in violation of Section 2 of the Sherman Act. There can be no finding of

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[5] Although this Court stated in its November 15, 2004 Order regarding the admissibility of Seaman's testimony that Seaman did conduct a "dynamic analysis", the results of that analysis are not persuasive in light of the economic realities of the Lafayette area.

conspiracy under Section 2 of the Sherman Act unless there is "evidence that two or more parties have knowingly participated in a common scheme or design to accomplish an anti-competitive purpose." *Wagner v. Magellan Health Services, Inc.,* 121 F.Supp.2d 673, 679 (N.D.Ill.2000) (citing *Albrecht v. Herald Co.,* 390 U.S. 145, 149, 88 S.Ct. 869, 19 L.Ed.2d 998 (1968); *American Tobacco Co. v. United States,* 328 U.S. 781, 809-10, 66 S.Ct. 1125, 90 L.Ed. 1575 (1946)). To establish a Section 2 conspiracy to monopolize, a plaintiff must prove: (1) a specific intent on the part of the defendants to achieve monopoly power; (2) predatory or anti-competitive conduct directed at accomplishing this purpose; and (3) a probability that the attempt will be successful. *Indiana Grocery v. Super Valu Stores,* 864 F.2d 1409, 1413 (7th Cir.1989). The evidence in this case establishes clearly that the decision to consolidate the OB unit at SEMC with the unit at HH was made unilaterally by the GLHS without any input from AA. This decision was made to reduce expenses, improve efficiency, and improve the quality of care. Therefore, the requisite specific intent was lacking. Furthermore, the facts relating to the decision not to renew Kochert's subcontract with AA have been established in the Tippecanoe County Court, and this Court may not now revisit those findings.

V. Count V Group Boycott Theory

Kochert alleges in Count V that AA's exclusive contract with HH expired in August 1996, that AA failed to renew it properly before August 1998, and that as a result, the defendants wrongly excluded her from practicing anesthesiology at HH on the basis of this ineffective agreement between 1996 and 1998.

As mentioned earlier, Kochert brought suit in state court seeking to recover damages against HH and AA because of the alleged nonrenewal of her subcontract in 1998. Summary judgment was entered in favor of HH and AA. Because there is identity of the causes of action, identity of parties and a final judgment adverse to Kochert, this count is barred by *res judicata. Roboserve, Inc. v. Kato Kagaku Co., Ltd.* 121 F.3d 1027, 1034 (7th Cir.1997). Furthermore, even if this Court were to revisit this claim, it is clearly without merit.

VI. Essential Facility Claim

Kochert alleges in Count XI that she has been denied access to practice at an essential facility, SEMC and HH, and that this refusal to grant her access to an essential facility violates Section 2 of the Sherman Act. To establish an essential facility claim, a plaintiff must show: 1) control of the essential facility by a monopoly; 2) a competitor's inability practically or reasonably to duplicate the essential facility; 3) the denial of the use of the facility to a competitor; and 4) feasibility of providing the facility. *MCI Communications Corp. v. American Telephone and Telegraph Co.,* 708 F.2d 1081, 1132-33 (7th Cir.1983), *cert. denied*, 464 U.S. 891, 104 S.Ct. 234, 78 L.Ed.2d 226 (1983). To establish denial, the plaintiff must show that there is no feasible alternative to the facility, and that denial to the facility would cause the plaintiff a "severe handicap," rather than simple inconvenience or economic loss. *City of Chanute, Kansas v. Williams Natural Gas Co.,* 955 F.2d 641 (10th Cir.1992).

Kochert's claims fail because of the availability of alternative facilities. According to Kochert's own expert,

Dr. Seaman, agreed that it was valid to include all surrounding counties in the relevant geographic area, and it is undisputed that there are other facilities in that area which also provide inpatient and obstetrical anesthesia services. Kochert is not foreclosed from providing anesthesia services to patients in this market. Therefore, she is unable to establish an essential element of her claim and summary judgment is appropriate.

VII. Kochert's State Antitrust Claims

Kochert's claims in Counts VI, VII, VII, IX, and X of her amended complaint are based on Indiana antitrust statutes. Because these counts are duplicative of Count I through V of her amended complaint, and because the same facts and theories relied upon by Kochert for her federal antitrust claims are relied upon in her state claims, those claims are not sufficient to withstand summary judgment.

CONCLUSION

Based on the foregoing, no genuine issue of material fact exists in regards to the claims brought by this Plaintiff and therefore such claims cannot be sustained. Summary judgment is thus **GRANTED** in favor of the Defendants and against Plaintiff on all counts and all claims. Each party will bear its own costs and fees. This is to be considered as a final appealable judgment in this case. **IT IS SO ORDERED.**

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF INDIANA
HAMMOND DIVISION AT LAFAYETTE

CAROLYN G. KOCHERT, M.D., Plaintiff, v. GREATER LAFAYETTE HEALTH SERVICES, INC., d/b/a ST. ELIZABETH MEDICAL CENTER and d/b/a LAFAYETTE HOME HOSPITAL, ANESTHESIOLOGY ASSOCIATES, P.C., and JOHN WALLING, Defendants.	)	Cause No. 4:01CV0027 AS

MEMORANDUM AND ORDER

(Filed Nov. 15, 2004)

On July 19, 2004, Defendant Greater Lafayette Health Services, Inc. ("GLHS") filed a motion to exclude the report and testimony of Dr. Bruce Seaman, Plaintiff's expert witness on economic and market analyses for the present case. On that same day, Defendant Anesthesiology Associates, P.C. ("AA") filed their own motion to exclude the testimony of Dr. Seaman. The court has received a substantial amount of evidence and heard extensive oral arguments from counsel on this matter. This issue at this stage of the proceedings is incredibly close and is here resolved in favor of the plaintiff. It should be noted at the outset that the fact that the proffered evidence has passed muster under a *Daubert* analysis does not ensure or decide whether such evidence is ultimately persuasive. It will be

necessary for this court to wade through that problem at another time, either during summary judgment or at trial.

In *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 509 U.S. 579 (1993), the Supreme Court held that district judges play a "gatekeeping" role in admitting expert testimony. *Daubert* required judges to determine that scientific testimony offered under Federal Rule of Evidence 702 is both relevant and reliable. *Daubert,* 509 U.S. at 593. This requirement was extended to fields of nonscientific expertise in *Khumo Tire Co. v. Carmichael,* 526 U.S. 137 (1999). Expert "[t]estimony is relevant if assists the trier of fact in understanding the evidence or in determining a fact at issue." *Masters v. Hesston Corp.,* 291 F.3d 985, 991 (7th Cir. 2002). To evaluate reliability, this Court "must determine whether the expert is qualified in the relevant field and whether the methodology underlying the expert's conclusions is reliable." *Id.*; *Smith v. Ford Motor Co.,* 215 F.3d 713, 719. When evaluating the reliability of expert testimony, this Court must focus "solely on principles and methodology, not on the conclusions they generate." *Chapman v. Maytag Corp.,* 297 F.3d 682, 687 (7th Cir. 2002). *Daubert* sets forth a nonexclusive list of factors that a court should consider: (1) whether the theory can be and has been verified by the scientific method through testing; (2) whether the theory has been subjected to peer review; (3) the known or potential rate of error; and (4) the general acceptance of the theory in the scientific community. The *Daubert* test is flexible, however, and there is no requirement that an expert's testimony satisfy each of these factors. *Id.* The framework outlined above will now be applied to Dr. Seaman's testimony.

In applying the two-step analysis required by *Daubert,* the Court must first determine whether Dr.

Seaman's testimony is relevant. *Daubert,* 509 U.S. at 593. In their motions to exclude Dr. Seaman's testimony, both AA and GLHS argue that his testimony is not relevant and would not assist the trier of fact in the resolution of the issues of this case. Both parties seem to confuse the relevance question with the reliability question, however. The subject matter of Dr. Seaman's testimony, defining the product and geographic markets, is not only relevant to this case, but is a central issue. As Defendant GLHS notes in its supporting brief, "the outcome of many antitrust cases hinges on which of the proffered markets the court ultimately accepts as the appropriate ones," and "the importance of proper market determination cannot be understated." *See* George A. Hay, *The Economist as Expert Witness, in Expert Witnesses,* 335 (Faust F. Rossi ed. 1991) ("[I]t is virtually unthinkable to attempt to litigate an anti-trust case without the use of economic testimony"). Though couched in terms of relevance, the defendants are essentially disputing the reliability of Dr. Seaman's testimony. As Kochert was proffering the testimony of Dr. Seaman to aid in defining the relevant market in the antitrust claims, Seaman's testimony would assist the trier of fact in resolving this issue.

The second step in the two-step analysis outlined in *Daubert* requires the Court to determine whether Dr. Seaman's testimony is reliable. *Daubert,* 509 U.S. at 593. As to this step of the analysis, our Court of Appeals uses two main criteria: "whether the expert is qualified in the relevant field and whether the methodology underlying the expert's conclusions is reliable." *Masters,* 291 F.3d at 991. Each of those will be examined in turn.

As to Dr. Seaman's qualifications, Rule 702 permits an expert to be qualified through "knowledge, skill, experience, training or education." Neither defendant disputes Dr. Seaman's qualifications and a review of his qualifications reveals that no dispute is warranted.

The heart of the defendants' arguments focus on the methodology underlying Dr. Seaman's conclusions and the reliability of that methodology. Collectively, the defendants argue that Dr. Seaman's testimony is not based upon sufficient facts or data, is not the product of reliable principals and methods, is based on speculation, is not reasonably grounded in the record, and that the principals and methods used have not been reliably applied to the facts of this case. More specifically, they argue that (1) Dr. Seaman incorrectly defined the relevant product market; (2) Dr. Seaman used incorrect methodology in defining the relevant geographic market and that his definitions are unreliable; and (3) that Dr. Seaman failed to due a dynamic analysis. Each of these specific arguments will be addressed in turn.

The Relevant Product Market

The defendants argue that Dr. Seaman incorrectly defined the relevant product market. There are two subparts to this argument. First, the defendants claim that Dr. Seaman incorrectly defined the relevant product market as anesthesia services, rather than anesthesiologists. Second, they argue that Dr. Seaman incorrectly concluded that the relevant product market consists of three separate markets for obstetrical anesthesia, outpatient surgical anesthesia, and inpatient surgical anesthesia. These sub-parts will be discussed separately.

In his report, Dr. Seaman concluded that, "The relevant product markets are anesthesia services provided in support of inpatient surgical procedures, and anesthesia services in support of obstetrical procedures, both requiring admission into a hospital for a stay of greater than 23 hours." (Seaman Report p. 35). The defendants, relying on *Collins v. Associate Pathologists Ltd.,* 844 F.2d 473 (7th Cir. 1988), argue that in cases involving an exclusive contract between a hospital and a physician Seventh Circuit case law requires the product market to be defined as anesthesiologists and not anesthesiology services. No reading of *Collins* could lead to that conclusion. *Collins* dealt with pathologists rather than anesthesiologists – a distinction this Court finds significant. In *Jefferson Parish v. Hyde,* 466 U.S. 2, 23 (1984), the Supreme Court expressly considered a market for both anesthesiologists and anesthesiology services. The Seventh Circuit declined to recognize similar separate markets in *Collins* because, unlike anesthesiologists, there was no separate demand for pathologists. *Collins,* 844 F.3d at 477). Moreover, the Court finds it significant that the defendants do not challenge Dr. Seaman's methodology in reaching this conclusion, but rather challenge the conclusion itself. As the Seventh Circuit explained in *Smith,* 215 F.3d at 719, "[i]t is not the trial court's role to decide whether an expert's opinion is correct. The trial court is limited to determining . . . whether the methodology underlying the testimony is sound." *See also, Deputy v. Lehman Bros., Inc.,* 345 F.3d 494, 506 (7th Cir. 2003).

Additionally, the defendants claim that Dr. Seaman erred in concluding that the relevant product market consists of three separate markets for obstetrical anesthesia, outpatient surgical anesthesia and inpatient surgical

anesthesia. The defendants rely on *Blue Cross & Blue Shield United of Wisconsin v. Marshfield Clinic,* 65 F.3d 1406 (7th Cir. 1995) and *Davies v. Genesis Medical Center,* 994 F. Supp. 1078 (S.D. Iowa 1998), to support this proposition. Nothing in those case indicate that the subdivision of the market by diagnostic related groups (DRGs) is so unreliable as to be excluded in a *Daubert* analysis. As noted above, one of the factors outlined in *Daubert and Khumo* for assessing the reliability of an expert's methodology is whether the method is accepted within the relevant academic community. The Plaintiff cites a paper by Zwanziger, Melnick and Eyre, "Hospitals and Antitrust: Defining Markets, Setting Standards," Journal of Health Politics, Policy and Law, Summer 1994, 19(2): 423-446:3, where "[e]mphasizing the physician as the key input into hospital treatments, Zwanziger *et al.,* would begin by grouping diagnostic groups (DRGs) into 48 'service categories' . . . essentially treating each DRG as a separate market from the demand side, this approach groups DRGs into [service categories] based on the least specialized physician capable of treating those diagnoses. Physician specialties are used as 'markers,' which in effect, identify that range of DRGs that an uncommitted hospital entrant could easily produce with the same personnel and equipment." Sacher and Silvia, "Antitrust Issues in Defining the Product Market for Hospital Services," *International Journal of Economics of Business,* v5, n2 (July 1998): 181-202. Furthermore, the defendants' economist Dr. Eisenstadt conceded that obstetrics and inpatient surgical anesthesia could be a relevant market "if plaintiff can demonstrate . . . that GLHS would not recruit a replacement group to competitively discipline AA should it attempt the exercise of market power." (Eisenstadt report pp. 24-25). He further conceded that he is unaware of any

such replacement group being imported into a local area from afar and that such a replacement might to up to a year to effectuate. (Eisenstadt 12/2/03 Dep. at p. 128). This evidence demonstrates that Dr. Seaman's methodology in defining the relevant product market is sufficiently reliable.

The Relevant Geographic Market

The defendants argue that Dr. Seaman incorrectly defined the relevant geographic market. Dr. Seaman used the Elzinga-Hogarty test ("E-H test") as the basis for defining the relevant geographic market. The test consists of two measurements – Lifo and Lofi. A Lofi or "little out from the inside" statistic represents the percentage of patients in an area's hospital who reside in the area, rather than outside the area. *See Rockford Memorial Corp.* 717 F. Supp. 1251, 1266 (N.D. Ill. 1989). This measurement is used to determine "whether a substantial number of patients from outside the area travel into an area for hospitalization," and, "[i]f so, that implies that hospitals located in the areas where those immigrating patients reside could act as a check on the exercise of market power by hospitals in the area." *Id.* (internal citations omitted). A "Lifo" or "little in from out" statistic represents the "percentage of hospital patients from a particular area who remain in that area for hospital services." *Id.* This measurement is used to determine "whether patients in a particular area make substantial use of hospitals outside the area," and "[i]f so, that implies that hospitals outside the area could act as a check on the exercise of market power by hospitals inside the area." *Id.* (internal citations omitted).

The defendants recognize that the E-H test is an appropriately reliable test for determining the relevant geographic market. However, they claim that Dr. Seaman did not properly apply the test and that the results of his application are not reliable. The defendants claim that Dr. Seaman failed to define a relevant geographic market whose Lifo and Lofi measurements are at least 90%, and that this failure is critical. The Court disagrees, and finds the language of *Rockford* instructive on this issue. The court in *Rockford,* referring to the 90% standard, stated, "[t]his guideline, however, other than setting general parameters, is of minimal utility." *Id.* at 1271-1272. The court further stated that "it is not wise or necessary to begin every new Elzinga-Hogarty inquiry with a specific percentage in mind. (For instance, the 90% figure is merely a preference)." *Id* at 1272. Finally, the court stated that "if reaching the 90% Lifo/Lofi figures is unrealistic, using a smaller percentage is no sin. The Elzinga-Hogarty test should be driven by common sense and not the other way around." *Id.* The Court also finds it significant that the cases cited by the defendants to support this argument did not involve *Daubert* challenges.[1] The courts in those cases clearly found E-H test results of below the 90% standard sufficiently reliable for consideration, if ultimately unpersuasive.

Furthermore, Dr. Seaman was able to demonstrate that his measurements would be acceptable within the

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[1] *Federal Trade Commission v. Freeman Hospital,* 69, F.3d 260 (8th Cir. 1995); *Federal Trade Commission v. Tenet Healthcare Corp.,* 186 F.3d 1045 (8th Cir. 1999); *California v. Suter Health System,* 130 F. Supp.2d 1109 (N.D. Cal., 2001); *Gordon v. Lewistown Hospital,* 272 F.Supp.2d 393 (MD Pa. 2003).

academic community. Dr. Seaman noted in his report that "economists have generally been very critical of judicial exceptions to the general finding of localized hospital service markets in several hospital merger cases. (Seaman report p. 47). Kochert also points out that economists have accepted relatively large geographic markets in comparison to the courts. She cites a journal article, Frech III, Langenfeld and McCluer, *Antitrust Law Journal* 71 (2004), which stated:

> Economic research literature on hospital competition tends to support this type of market definition. In analyzing hospital competition, researchers often use fairly small pre-defined areas, such as counties or SMSA's . . . Sometimes, they have used pure distance measures from the merging hospitals, with radiuses in the 10 to 20 mile range. Despite the research, the court decisions issued in the last several years have found much larger geographic markets.

The *Daubert* test requires that the expert's methodology is reliable and accepted within the relevant academic or scientific community, not that the results of that methodology are ultimately persuasive to the courts. *See Daubert,* 509 U.S. 579; *Smith v. Ford Motor Co.,* 215 F.3d 713, 718 (7th Cir. 2000) ("the court's gatekeeping function focuses on an examination fo the expert's methodology. The soundness of the factual underpinnings of the expert's analysis and the correctness of the expert's conclusions based on that analysis are factual matters to be determined by the trier of fact, or, where appropriate, on summary judgment").

Finally, in addition to satisfying the *Daubert* factor of being accepted within the relevant academic community,

Dr. Seaman's analysis is sufficiently objective to be challenged by the defendants. *Khumo,* 526 U.S. at 149 (the factors for assessing the reliability of expert testimony include whether the technique can be tested). In other words, the E-H test, as used by Dr. Seaman, is sufficiently objective so that the results of its applications may be tested and challenged by the defendants. It is not a purely subjective, conclusory approach that cannot be assessed for reliability.

The defendants also claim that Dr. Seaman's testimony is unreliable because he made no attempt to calculate the hospital's service area using patients' zip codes, instead aggregating the data by county. The defendants argue that aggregating the data by county is less accurate and less precise than using zip codes. *Daubert* does not require the most accurate or most precise methodology possible to be applied, but rather that the methodology that is applied is accurate. *See Heller v. Shaw Industries, Inc.,* 167 F.3d 146, 160 (3d Cir. 1999) (expert testimony cannot be excluded simply because the expert uses one test rather than another, when both tests yield reliable results). As Kochert points out, however, economic literature demonstrates that Dr. Seaman's approach, if not the absolute best approach, is at least reliable. She points to the Wilder and Jacobs study ("Antitrust Considerations for Hospital Mergers: Market Definition and Market Concentration," in R. Scheffler and L. Rossner, eds., *Advances in Health Economics and Health Services Research 7* (1987)). That study examined markets at the county level of aggregation using the E-H Lifo and Lofi rules. Another article, Morrisey, Sloan & Valvona, in "Defining Geographic Markets for Hospital Care," *Law and Contemporary Problems,* v. 51, n2 (Spring 1989): 174, cites the

Wilder and Jacobs study and states, "Wilder and Jacobs were the only analysts to explicitly compare their market to the conditions of market definition found in the economics literature." The plaintiff also cites Luft and Maerki ("Competitive Potential of Hospitals and the Neighbors," *Contemporary Policy Issues* (1984-85), who, according to Morrison, *et al.,* "made the most extensive examination of the geographic market for hospital care and the effects of concentration to date," (*Id.* at 174), but neither zip codes nor counties were used as the primary unit of their analysis. Similarly, Frech III *et al.,* (2004, cited above) discuss the possible use of an "expanding radius approach" in the application of the Elzinga-Hogarty analysis. These articles demonstrate that the zip code approach is not the only acceptable method in calculating a hospital's service area.

Dynamic Analysis

The defendants claim that Dr. Seaman's testimony is unreliable because he failed to do a dynamic analysis. Both Kochert and the defendants recognize that a dynamic analysis is a necessary step in defining the relevant geographic market. *See Freeman,* 69 F.3d at 269. The question is whether Dr. Seaman did indeed perform an acceptable dynamic analysis. The Court is persuaded that Dr. Seaman did perform a dynamic analysis.

The E-H test results in a static, rather than dynamic, picture of the geographic area. It describes patients' actual, current practices, and fails to account for where patients could practically turn for alternative sources of the relevant product if faced with anti-competitive behaovior. The result is an incomplete market analysis. Dr. Seaman, however, recognized that other hospitals would

be alternatives to GLHS and AA. (Seaman 01/28/04 Dep. p. 279-281). He did not agree with the defendants as to which hospitals offered viable alternative suppliers of comparable quality. Dr. Seaman explained that his determinations were motivated by an effort to avoid the so-called "cellophane fallacy" of incorrectly finding alternative suppliers to be effective competitors only because the quality adjusted price had risen substantially. (Seaman 1/28/04 Dep.p. 247. *See U.S. v. E.I.U. du Pont de Nemours & Co.,* 351 U.S. 377 (1956); *U.S. v. Eastman Kodak Co.,* 63 F.3d 95 (2d. Cir. 1995). Again, the defendants are free to challenge Dr. Seaman's conclusions about the relevant geographic area through "[v]igorous cross-examination [and] presentation of contrary evidence." *Daubert,* 509 U.S. at 595.

Conclusion

After carefully reviewing the evidence on this issue, including the many submissions by the parties and extensive oral arguments, the Court finds that the Testimony of Dr. Bruce Seaman is sufficiently relevant and reliable to meet the evidentiary standards set forth in *Daubert and Khumo Tire.* Therefore, the motions by defendants GLHS and AA to exclude the testimony of Dr. Bruce Seaman are **DENIED**.

SO ORDERED.

Date: November 15, 2004

s/ Allen Sharp
ALLEN SHARP, JUDGE
UNITED STATES
DISTRICT COURT

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF INDIANA
HAMMOND DIVISION AT LAFAYETTE

CAROLYN G. KOCHERT, M.D., Plaintiff, v. GREATER LAFAYETTE HEALTH SERVICES, INC., d/b/a ST. ELIZABETH MEDICAL CENTER and d/b/a LAFAYETTE HOME HOSPITAL, ANESTHESIOLOGY ASSOCIATES, P.C., and JOHN WALLING, Defendants.	) Cause No. 4:01CV0027 AS

MEMORANDUM AND ORDER

(Filed Nov. 15, 2004)

On July 19, 2004, Defendant Greater Lafayette Health Services, Inc. ("GLHS") filed a motion to exclude the report and testimony of Paul Gertler (Gertler), Plaintiffs expert witness on contractual arrangements and their effect on pricing for the present case. On that same day, Defendant Anesthesiology Associates, P.C. ("AA") filed their own motion to exclude the testimony of Gertler. The court has received a substantial amount of evidence and heard extensive oral arguments from counsel on this matter. After careful consideration of this issue the Court resolves it in favor of the Plaintiff. It should be noted at the outset that the fact that the proffered evidence has passed muster under a *Daubert* analysis does not ensure or decide whether such evidence is ultimately persuasive. It will be necessary for this court to wade through that

problem at another time, either during summary judgment or at trial.

The defendants argue that Gertler's testimony should be excluded because it (1) is irrelevant and will not assist the trier of fact to determine a fact at issue in this case, (2) fails to meet the reliability tests set forth in *Daubert,* and (3) is not based on any facts or data applicable to this case.

In *Daubert v. Merrell Dow Pharmaceuticals, Inc.,* 509 U.S. 579 (1993), the Supreme Court held that district judges play a "gatekeeping" role in admitting expert testimony. *Daubert* required judges to determine that scientific testimony offered under Federal Rule of Evidence 702 is both relevant and reliable. *Daubert,* 509 U.S. at 593. This requirement was extended to fields of nonscientific expertise in *Khumo Tire Co. v. Carmichael,* 526 U.S. 137 (1999). Expert "[t]estimony is relevant if assists the trier of fact in understanding the evidence or in determining a fact at issue." *Masters v. Hesston Corp.,* 291 F.3d 985, 991 (7th Cir. 2002). To evaluate reliability, this Court "must determine whether the expert is qualified in the relevant field and whether the methodology underlying the expert's conclusions is reliable." *Id.*; *Smith v. Ford Motor Co.,* 215 F.3d 713, 719. When evaluating the reliability of expert testimony, this Court must focus "solely on principles and methodology, not on the conclusions they generate." *Chapman v. Maytag Corp.,* 297 F.3d 682, 687 (7th Cir. 2002). *Daubert* sets forth a nonexclusive list of factors that a court should consider: (1) whether the theory can be and has been verified by the scientific method through testing; (2) whether the theory has been subjected to peer review; (3) the known or potential rate of error; and (4) the general acceptance of the theory in the scientific community. The *Daubert* test is flexible, however, and

there is no requirement that an expert's testimony satisfy each of these factors. *Id.* The framework outlined above will now be applied to Gertler's testimony.

Relevance

In applying the two-step analysis required by *Daubert,* the Court must first determine whether Gertler's testimony is relevant. Expert "[t]estimony is relevant if assists the trier of fact in understanding the evidence or in determining a fact at issue." *Masters,* 291 F.3d at 991. In this case, Gertler's testimony is relevant. It will aid the trier of fact in arriving at a decision of whether exclusive contracts increased pricing, improved efficiencies or heightened quality of care provided patients by the anesthesiologists within the exclusive group. *See Smith v. Ford Motor Co.,* 215 F.3d 715, 721 (7th Cir. 2000) ("in order for an expert's testimony to qualify as 'relevant' under Rule 702 it must assist the jury in determining *any* fact at issue in the case . . . the expert's testimony need not relate to the ultimate issue in order to be relevant under Rule 702") (emphasis in original). As for the effectiveness of Gertler's testimony or the results of those theories, those are not the proper subjects of a *Daubert* challenge.

Reliability

The second step in the two-step analysis required by *Daubert* requires the Court to determine whether Gertler's testimony is reliable. *Daubert,* 509 U.S. at 593. As to this step of the analysis, our Court of Appeals uses two main criteria: "whether the expert is qualified in the relevant field and whether the methodology underlying the expert's conclusions is reliable." *Masters,* 291 F.3d at 991. The

defendants do not dispute Gertler's academic credentials, general experience or expertise, but instead focus on the reliability of the theory set forth in Gertler's paper. The defendants make much of the fact that Gertler's paper has not been published or peer reviewed. The factors outlined in *Daubert* are not exclusive or dispositive, however, and the "trial judge must have considerable leeway in deciding in a particular case how to go about determining whether particular expert testimony is reliable." *Khumo,* 526 U.S. at 151. As Kochert points out, Gertler has presented the article in front of the following: the FTC, the American Economic Association, the Conference on Industrial Organization and Market Structure in Healthcare in Rochester, the annual meetings of the Health Economics Association, Harvard University, MIT, Princeton, Yale, Cornell, Carnegie Mellon, University of Chicago, Northwestern, UCLA, University of California Berkeley, University of Duluth, at the European Industrial Organization meetings, at the Latin American Econometric Society Meetings, at the University of San Adres in Argentina, and at the Vargas Institute in Rio de Janeiro (Gertler Dep. at pp. 12-13). Gertler stated that "the comments [to his article presented at conferences] by and large were very favorable, supportive and suggested further analyses to check the robustness of the results." (Gertler Dep. at p. 14). That Gertler's paper has not been published or subjected to peer review is not fatal to his testimony. The Supreme Court stated in *Daubert* that "some propositions are too particular, too new, or of too limited interest to be published." 509 U.S. at 593-4 (1993). At least one federal court has held that, "presentation of papers at conferences and conventions subjects the contents of those presentations and the opinions expressed therein [to] peer review." *U.S. v. Everrett,* 972 F.Supp. 1313, 1324 (D. Nev. 1997).

Furthermore, it is clear from Gertler's deposition testimony that his theory and paper were developed independently litigation. As the court stated in *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 43 F.3d 1311, 1317 (9th Cir. 1995), "that an expert testifies based on research he has conducted independent of the litigation provides important, objective proof that the research comports with the dictates of good science." (citing Peter W. Huber, Galileo's Revenge: Junk Science in the Courtroom 206-09 (1991) (describing how the practice of expert-shopping leads to bad science)). These factors lead the Court to conclude that Gertler's testimony is reliable.

Testimony Based on Facts or Data Applicable to the Case

The defendants' final argument is that Gertler's testimony should be excluded because it is not based on facts or data applicable to the case. They point out that Gertler has not studied the Lafayette, Indiana market and that his paper does not address that area. As the defendants' recognize in their brief, however, Gertler did use information regarding the demographic makeup of Tippeacanoe County and the counties contiguous to Tippeacanoe County. Gertler obtained this information from the Bureau of Census (Gertler Dep. at p. 28) and concluded that the area was not a metropolitan statistical area and that there was not a larger number of hospitals in the area. (Gertler Dep. at p. 28). *See Clinchfield R. Co. v. Lynch,* 784 F.2d 545, 553-54 (4th Cir. 1986) (affirming admission of economist's expert testimony based on census data). Furthermore, as Gertler explained in his deposition, he did not need to know highly specific information about the area,

but only whether there existed a fully integrated organizational form. That is, whether GLHS consisted of a large not-for-profit teaching hospital in a large statistical area which buys a physician group and makes those physicians its employees, so that there is no separation. (Gertler Dep. at p. 157). If knowing that specific information would not have affected his opinions, it cannot be essential that he obtain that information.

Conclusion

After carefully reviewing the evidence on this issue, including the many submissions by the parties and extensive oral arguments, the Court finds that the Testimony of Paul Gertler is sufficiently relevant and reliable to meet the evidentiary standards set forth in *Daubert and Khumo Tire*. Therefore, the motions by defendants GLHS and AA to exclude the testimony of Paul Gertler are **DENIED**.

SO ORDERED.

Date: November 15, 2004 /s/ Allen Sharp
ALLEN SHARP, JUDGE
UNITED STATES
DISTRICT COURT

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF INDIANA
HAMMOND DIVISION AT LAFAYETTE

CAROLYN G. KOCHERT, M.D., Plaintiff, v. GREATER LAFAYETTE HEALTH SERVICES, INC., d/b/a ST. ELIZABETH MEDICAL CENTER and d/b/a LAFAYETTE HOME HOSPITAL, ANESTHESIOLOGY ASSOCIATES, P.C., and JOHN WALLING, Defendants.	) Cause No.) 4:01CV0027 AS

MEMORANDUM AND ORDER

(Filed Nov. 15, 2004)

On July 19, 2004, Defendant Anesthesiology Associates, P.C. ("AA") filed a motion to exclude the report and testimony of Dr. Stephen Minore. Plaintiff retained Dr. Minore for the purpose of explaining the meaning of ASA standard I and to opine on the issues of quality of care. The court has received a substantial amount of evidence and heard extensive oral arguments from counsel on this matter. After careful consideration of this issue the Court resolves it in favor of the Plaintiff. It should be noted at the outset that the fact that the proffered evidence has passed muster under a *Daubert* analysis does not ensure or decide whether such evidence is ultimately persuasive. It will be necessary for this court to wade through that problem at another time, either during summary judgment or at trial.

The defendant argues that Dr. Minore's testimony should be excluded because it fails to meet the reliability tests set forth in *Daubert* and his opinions do not aid the fact finder.

In *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 509 U.S. 579 (1993), the Supreme Court held that district judges play a "gatekeeping" role in admitting expert testimony. *Daubert* required judges to determine that scientific testimony offered under Federal Rule of Evidence 702 is both relevant and reliable. *Daubert,* 509 U.S. at 593. This requirement was extended to fields of nonscientific expertise in *Khumo Tire Co. v. Carmichael,* 526 U.S. 137 (1999). Expert "[t]estimony is relevant if assists the trier of fact in understanding the evidence or in determining a fact at issue." *Masters v. Hesston Corp.,* 291 F.3d 985, 991 (7th Cir. 2002). To evaluate reliability, this Court "must determine whether the expert is qualified in the relevant field and whether the methodology underlying the expert's conclusions is reliable." *Id.*; *Smith v. Ford Motor Co.,* 215 F.3d 713, 719. When evaluating the reliability of expert testimony, this Court must focus "solely on principles and methodology, not on the conclusions they generate." *Chapman v. Maytag Corp.,* 297 F.3d 682, 687 (7th Cir. 2002). *Daubert* sets forth a nonexclusive list of factors that a court should consider: (1) whether the theory can be and has been verified by the scientific method through testing; (2) whether the theory has been subjected to peer review; (3) the known or potential rate of error; and (4) the general acceptance of the theory in the scientific community. The *Daubert* test is flexible, however, and there is no requirement that an expert's testimony satisfy each of these factors. *Id.* The framework outlined above will now be applied to Gertler's testimony.

Application of the standards outlined in *Daubert* requires the Court to determine whether Gertler's testimony is reliable. *Daubert,* 509 U.S. at 593. As to this step of the analysis, our Court of Appeals uses two main criteria: "whether the expert is qualified in the relevant field and whether the methodology underlying the expert's conclusions is reliable." *Masters,* 291 F.3d at 991. AA does not dispute Dr. Minore's qualifications, background or experience. AA does, however, claim that Dr. Minore's testimony is not reliable. Specifically, AA argues that Minore used the ASA report and other data in an unacceptable manner, distorted and misapplied the data, has not adequately investigated the issues in the case, lacks firsthand knowledge of incidents on which he bases his opinion, and is unfamiliar with the testimony of other witnesses.

Kochert claims that the purpose of Dr. Minore's testimony is to explain the meaning of ASA Standard I and to opine on the issues of quality of care. Dr. Minore is a full-time anesthesiologist who has also testified in several cases. Dr. Minore reviewed the ASA report, depositions and affidavits, and opined as to what should have been done for quality of care or quality assurance programs. The Seventh Circuit has affirmed the admission of testimony by a physician as to the standard of care required in the medical field, even when the physician witness had limited knowledge of the practitioners in question. *Cooper v. Eagle River Memorial Hospital Inc.,* 270 F.3d 456, 463 (7th Cir. 2001). In Cooper, the witness in question was a physician who testified as to the standard of care required of nurse practitioners. That physician's role was largely administrative and the court recognized that the physician had only limited experience with nurse practitioners.

Nevertheless the court affirmed the admission of her testimony, stating that "[t]rial judges have broad discretion in determining expert qualifications and their determination will be affirmed unless it is manifestly erroneous." *Id.* The court further noted that the opponent of the testimony could "quarrel with the conclusions reached by [the physician], but her qualifications are not so limited" as to require exclusion of her testimony. *Id. See also Schneider v. Fried,* 320 F.3d 396, 407 (3d Cir. 2003). (finding the testimony of a physician reliable even though he was not an expert in the sub-specialty about which he opined; and noting the witness's academic background and his teaching).

Furthermore, AA's objections to the testimony of Dr. Minore go to the weight of his testimony and not the reliability of that testimony. *See Boyar v. Korean Airlines,* 954 F. Supp. 4 (D.C. Cir. 1996) ("[a]lthough expert testimony should be excluded if it is speculative or conjectural, or if it is based on assumptions that are so unrealistic and contradictory as to suggest bad faith or to be in essence an apples and oranges comparisons, other contentions that the assumptions are unfounded go to weight, not admissibility of the testimony"). A review of the case law after *Daubert* shows that the rejection of expert testimony is the exception rather than the rule. *Daubert* did not work a "seachange over federal evidence law," and "the trial court's role as gatekeeper is not intended to serve as a replacement for the adversary system." *U.S. v. 14.38 Acres of Land Situated in Leflore County, Mississippi,* 80 F.3d 1074 (5th Cir. 1996). As the court in *Daubert* stated, "[v]igorous cross-examination, presentation of contrary evidence, and careful instruction on the burden of proof are the traditional and appropriate means of attacking

shaky but admissible evidence. 509 U.S. at 595. Dr. Minore's testimony appears to the Court to be more than mere "subjective belief or unsupported speculation." *Deimer v. Cincinnati Sub-Zero Prods., Inc.,* 58 F.3d 341, 344 (7th Cir. 1995). Any inconsistencies between his opinions and the evidence he reviewed or failed to review can be explored on cross-examination.

Finally, even if Dr. Minore failed to review the testimony of other witnesses his testimony should not be excluded. *See Walker v. Soo Line,* 208 F.3d 581, 591 (7th Cir. 2000) (if there was reason to believe that the expert witness's investigation was shoddy, the opponent of that testimony could have uncovered those flaws through cross-examination and the presentation of contrary evidence); *Westberry v. Gislaved Gummi,* 178 F.3d 257, 265 (4th Cir. 1999) (alternative causes normally affect the weight that the jury should give the expert's testimony and not the admissibility of that testimony). It appears from the evidence that Dr. Minore did review a sufficient amount of evidence, and any failure to review testimony of other witnesses does not render his testimony unreliable.

Conclusion

After carefully reviewing the evidence on this issue, including the many submissions by the parties and extensive oral arguments, the Court finds that the Testimony of Dr. Minore is sufficiently relevant and reliable to meet the evidentiary standards set forth in *Daubert* and *Khumo Tire.* Therefore, the motion by AA to exclude the testimony of Dr. Minore is **DENIED**.

SO ORDERED.

Date: November 15, 2004 /s/ ALLEN SHARP
ALLEN SHARP, JUDGE
UNITED STATES
DISTRICT COURT

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF INDIANA
HAMMOND DIVISION AT LAFAYETTE

CAROLYN G. KOCHERT, M.D., Plaintiff, v. GREATER LAFAYETTE HEALTH SERVICES, INC., d/b/a ST. ELIZABETH MEDICAL CENTER and d/b/a LAFAYETTE HOME HOSPITAL, ANESTHESIOLOGY ASSOCIATES, P.C., and JOHN WALLING, Defendants.	) Cause No. 4:01CV0027 AS

MEMORANDUM AND ORDER

(Filed Nov. 15, 2004)

On July 19, 2004, Defendant Anesthesiology Associates, P.C. ("AA") filed a motion to exclude the report and testimony of Cornelius A. Hofman ("Hofman"). Plaintiff retained Hofman as a damages expert. The court has received a substantial amount of evidence and heard extensive oral arguments from counsel on this matter. After careful consideration of this issue the Court resolves it in favor of the Plaintiff. It should be noted at the outset that the fact that the proffered evidence has passed muster under a *Daubert* analysis does not ensure or decide whether such evidence is ultimately persuasive. It will be necessary for this court to wade through that problem at another time, either during summary judgment or at trial.

The defendant argues that Hofman's testimony should be excluded because it irrelevant and premature and fails to meet the reliability tests set forth in *Daubert.*

In *Daubert v. Merrell Dow Pharmaceuticals, Inc.,* 509 U.S. 579 (1993), the Supreme Court held that district judges play a "gatekeeping" role in admitting expert testimony. *Daubert* required judges to determine that scientific testimony offered under Federal Rule of Evidence 702 is both relevant and reliable. *Daubert,* 509 U.S. at 593. This requirement was extended to fields of nonscientific expertise in *Khumo Tire Co. v. Carmichael,* 526 U.S. 137 (1999). Expert "[t]estimony is relevant if assists the trier of fact in understanding the evidence or in determining a fact at issue." *Masters v. Hesston Corp.,* 291 F.3d 985, 991 (7th Cir. 2002). To evaluate reliability, this Court "must determine whether the expert is qualified in the relevant field and whether the methodology underlying the expert's conclusions is reliable." *Id.*; *Smith v. Ford Motor Co.,* 215 F.3d 713, 719. When evaluating the reliability of expert testimony, this Court must focus "solely on principles and methodology, not on the conclusions they generate." *Chapman v. Maytag Corp.,* 297 F.3d 682, 687 (7th Cir. 2002). *Daubert* sets forth a nonexclusive list of factors that a court should consider: (1) whether the theory can be and has been verified by the scientific method through testing; (2) whether the theory has been subjected to peer review; (3) the known or potential rate of error; and (4) the general acceptance of the theory in the scientific community. The *Daubert* test is flexible, however, and there is no requirement that an expert's testimony satisfy each of these factors. *Id.* The framework outlined above will now be applied to Hofman's testimony.

In applying the two-step analysis required by *Daubert,* the Court must first determine whether Hofman's testimony is relevant. *Daubert,* 509 U.S. at 593. In its motion to exclude Hofman's testimony, AA argues that his testimony is not relevant because the issue of damages is irrelevant and premature at this stage of the proceeding and Hofman's analysis does not aid the trier of fact. Hofman was retained by the plaintiff to testify regarding the damages Kochert purportedly sustained as result of the actions which gave rise to her claims in this case. Kochert is required, even at the summary judgment stage, to show that she has suffered damages. To survive summary judgment, Kochert must demonstrate under Federal Rule of Civil Procedure 56 that a question of material fact exists as to her injuries. Furthermore, Kochert has demonstrated that Hofman's calculations include dates after June 1, 2001, making them relevant even if the Court accepts that date as the commencement of Kochert's action. Therefore, the issue of damages is relevant to the issues in this case.

The second step in the two-step analysis outlined in *Daubert* requires the Court to determine whether Hofman's testimony is reliable. *Daubert,* 509 U.S. at 593. As to this step of the analysis, our Court of Appeals uses two main criteria: "whether the expert is qualified in the relevant field and whether the methodology underlying the expert's conclusions is reliable." *Masters,* 291 F.3d at 991. AA claims that Hofman is not a qualified expert in the area of damages. Rule 702 requires that an expert be qualified through "knowledge, skill, experience, training, or education." Hofman has an MBA from the University of Chicago in Economics and Finance, has experience in economic consulting, and has given several presentations

and lectures on topics in economics and finance. In Hofman's case, his education, experience, and training are sufficient to qualify him as an expert under Rule 702.

AA also argues that the methodology underlying Hofman's opinions is unreliable. AA claims that Hofman's damage calculation was based on a novel and unsupported approach, is conclusory, and contains legal opinions masquerading as expert testimony. Specifically, AA argues that Hofman overstated the expenses Kochert incurred in opening her pain practice, failed to make an overall assessment of Kochert's entire financial situation, and uses only one year of data. While these claims might call into question the weight to be given to Hofman's testimony, they do not demonstrate that his methodology was unreliable. *See Walker v. Soo Line,* 208 F.3d 581, 591 (7th Cir. 2000) ("if there was reason to believe that [the expert witness's] investigation was shoddy, [plaintiff] could have uncovered those flaws through cross-examination and through presentation of contrary evidence"). Additionally, Hofman's deposition testimony demonstrates that he did consider data beyond 2001. (Hofman Dep. pp. 89-90, 149). Hofman's approach does not seem particularly novel. As the court recognized in *Garcia v. Columbia Medical Center of Sherman,* 996 F. Supp. 617, 623 (E.D. Tex. 1998), "[i]t is a commonly accepted practice in the field of economics to calculate future lost earnings based upon a worker's work-life probability and then adjust these figures for growth and inflation." The Court reiterates that a *Daubert* challenge is not a substitute for an adversary proceeding. As the court in *Daubert* stated, "[v]igorous cross-examination, presentation of contrary evidence, and careful instruction on the burden of proof are the traditional and appropriate means of attacking shaky but admissible evidence." 509 U.S. 595.

Conclusion

After carefully reviewing the evidence on this issue, including the many submissions by the parties and extensive oral arguments, the Court finds that the Testimony of Hofman is sufficiently relevant and reliable to meet the evidentiary standards set forth in *Daubert and Khumo Tire*. Therefore, the motion by AA to exclude the testimony of Hofman is **DENIED**.

SO ORDERED.

Date: November 15, 2004 /s/ ALLEN SHARP
ALLEN SHARP, JUDGE
UNITED STATES
DISTRICT COURT

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF INDIANA
HAMMOND DIVISION AT LAFAYETTE

CAROLYN KOCHERT, M.D., Plaintiff,	)	
v.	)	Civil No. 4:01cv0027AS
GREATER LAFAYETTE HEALTH SERVICES, INC., d/b/a ST. ELIZABETH MEDICAL CENTER, and d/b/a LAFAYETTE HOME HOSPITAL, ANESTHESIOLOGY ASSOCIATES, P.C., JOHN WALLING and KENNETH BOCHENEK, M.D., Defendants.	)	

MEMORANDUM AND ORDER

This matter is before the court on the Defendants', Greater Lafayette Health Services Inc. (Hereinafter referred to as "GLHS"), John Walling, Anesthesiology Associates, P.S. (Hereinafter referred to as "AA") and Dr. Kenneth Bochenek, various motions to dismiss pursuant to Rule 12 of the Federal Rules of Civil Procedure. Jurisdiction is conferred upon this court pursuant to 28 U.S.C. §§ 1331; 1337(a). For the following reasons the Defendants' motions are now **DENIED.**

I. BACKGROUND

The Plaintiff, Dr. Carolyn Kochert, has alleged that GLHS, Walling, AA and Dr. Bochenek have engaged in the following unlawful acts: conspiracy to restrain trade,

monopolization, group boycott/exclusive dealing, essential facility and tying. In her amended complaint she seeks damages and injunctive relief for these acts under the Sherman Antitrust Act, 15 U.S.C. §§ 1; 2, Clayton Antitrust Act, 15 U.S.C. § 4 and under Indiana state law, specifically Ind. Code §§ 24-1-2-(1-2).

Dr. Kochert is a board certified anesthesiologist licensed to practice medicine in the state of Indiana. (Plaintiff's Amended Complaint at ¶ 7). She has resided and practiced in Lafayette, Indiana since 1985. (Id.). The Defendant, GLHS, is the parent company of Lafayette Home Hospital and St. Elizabeth Medical Center. (P's Amend. Compl. at ¶ 13). Dr. Kochert has practiced at both of these hospitals in some capacity or another since 1985 and she currently has clinical privileges at both hospitals. (P's Amend. Compl. at ¶ 7). John Walling was the president and chief executive officer of GLHS at all relevant times to this suit.

Walling has for several years entered into an exclusive agreement with the Defendant Dr. Kenneth Bochenek, M.D. on behalf of his group anesthesia group, AA, to provide anesthesia services to GLHS. (P's Amend. Compl. at ¶¶ 16-17). The gravamen of Dr. Kochert's complaint is that in seeking these exclusive agreements with AA, GLHS has failed to notify or invite any of the other anesthesia groups or practicing anesthesiologists to submit bids or proposals to provide the anesthesia services to the hospitals controlled by GLHS. In turn, she alleges, this exclusive agreement has led to the elimination of almost half of the market for anesthesiology providers in a hospital setting, reduced consumer choice and increased costs to an anti-competitive level.

II. STANDARD OF REVIEW

The appropriate standard of review at the motion to dismiss stage requires the court to accept the factual allegations contained in the complaint as true. *Sanner v. Board of Trade of City of Chicago,* 62 F.3d 918, 925 (7th Cir.1995). "Adjunct to this principle is the requirement that [the court] view those allegations in the light most favorable to the plaintiff and make all reasonable inferences in [her] favor." *Sanner,* 62 F.3d at 925. Moreover, "... the defendant cannot, in presenting its 12(b)(6) challenge, attempt to refute the complaint or to present a different set of allegations." *Id.* This standard is not altered by a motion to dismiss under Rule 12(b)(1). *Sanner* at 925. The court must accept the Plaintiff's factual allegations and resolve any doubts in her favor. *Id.*

III. DISCUSSION

The underlying premise of the antitrust laws is to protect competition rather than to protect an individual competitor or competitors from the effects of competition. See *Zenith Radio Corp. v. Hazeltine Research, Inc.,* 395 U.S. 100, 125 (1969); *Brillhart v. Mutual Medical Ins., Inc.,* 768 F.2d 196 (7th Cir.1985). This underlying premise makes sense in that the purpose of the antitrust laws were enacted to promote competition and not to provide some private cause of action for an individual competitor that failed to sell his product, successfully win an exclusive contract or to guarantee every competitor tenure in the marketplace. See *Great Escape, Inc. v. Union City Body Co.,* 791 F.2d 532 (7th Cir.1986). "The core question in antitrust is output. Unless a contract reduces output in some market, to the detriment of consumers, there is no antitrust problem." *Chicago Professional Sports, Ltd.*

Partnership v. National Basketball Association, 95 F.3d 593, 597 (7th Cir. 1996). However, these determinations are highly fact sensitive. *Eastman Kodak Co. v. Image Technical Servs., Inc.,* 504 U.S. 451, 482, 112 S.Ct. 2072, 119 L.Ed.2d 265 (1992); *FTC v. Tenet Health Care Corp.,* 186 F.3d 1045, 1052 (8th Cir.1999); see also *Crounse Corp. v. ICC,* 781 F.2d 1176, 1188 (6th Cir.1986).

In *Jefferson Parish Hospital Dist.No.2 v. Hyde,* 466 U.S. 2, the Supreme Court was called upon to determine whether an exclusive contract between a hospital and an anesthesia group constituted an unlawful tying claim in violation of the Sherman Antitrust Act. It is important to note that the Court's ruling on both the per se violation as well as the rule of reason violation involved a well developed factual record. That record included an analysis of the percentage of patients who used the Defendant hospital as well as the percentage of patients using other hospitals in the relevant market. *Id.* at 26-27. The court concluded that Hyde had failed to come forward with any showing of an actual adverse effect on competition. *Id.* at 31.

Here the Plaintiff's Amended Complaint is replete with allegations that the Defendants' illegal conduct has an adverse effect upon competition both for herself and other anesthesia providers and patients. See (P's Amend. Compl. at ¶¶ 57, 78, 88, 97). The Plaintiff has alleged various claims under the antitrust law which under the governing standard involving a motion to dismiss under Rule 12(b)(6) must be given the presumption of correctness. That being said the Plaintiff faces a very high hurdle established by the numerous cases involving an exclusive contract between a hospital and a medical services provider. See *BCB Anesthesia Care v. Passavant Mem. Area*

Hosp., 36 F.3d 664, 667 (exhaustive list of cases dealing with antitrust claims brought by health care service providers.) However, it is this court's view that dismissal at the pleading stage may not be had. The Defendants in their various motions to dismiss rely on several facts that may not be relied upon at this stage of the proceeding. (For Example, see Reliance upon P's Dep. testimony as to her desire to do obstetrical anesthesia; GLHS Reply Memo. at p.3; Definition of relevant market; Id. at p. 4).[1]

The court is well aware of the costs involved in high stakes civil litigation and is well aware that a Defendant will seek to limit a Plaintiff's claims at each and every opportunity. However, it is this court's opinion that dismissal based upon the pleadings alone would run counter to the principles of civil jurisprudence in this matter. See *BCB Anesthesia Care v. Passavant Mem. Area Hosp.*, 36 F.3d 664, 669 (Cudahy Dissenting). Therefore the Defendants' motions to dismiss are now **DENIED**. The oral argument hearing currently set on February 22, 2002 at

[1] The court agrees that Dr. Kochert has attempted to define the relevant market as Tippecanoe County and the surrounding counties in her complaint. However, it is uncertain, at this stage of the proceeding without a factual inquiry, whether the consumers or providers go outside of the surrounding counties to receive hospital and anesthesia services. If this were true then Kochert's claims would most likely fail in light of the numerous hospital in the Indianapolis area. See Jefferson, 466 U.S. at 31. Moreover, at this stage it is uncertain whether those hospitals within the relevant market defined by Dr. Kochert provide the same type of services that are covered under the exclusive agreement between GLHS and AA. Thus, a more in depth factual determination must be had before any effects upon competition can be made.

1:30 p.m. in Lafayette, Indiana, is now reset as a pretrial conference. **IT IS SO ORDERED.**

Dated : **JANUARY 11, 2002** /s/ Allen Sharp
ALLEN SHARP, JUDGE
UNITED STATES
DISTRICT COURT

cc: all counsel

IN THE UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF INDIANA HAMMOND DIVISION AT LAFAYETTE

CAROLYN G. KOCHERT, M.D.,	)	
	)	
Plaintiff,	)	**Civil No.**
vs.	)	**4:01CV0027AS**
GREATER LAFAYETTE HEALTH SERVICES, INC., d/b/a ST. ELIZABETH MEDICAL CENTER and d/b/a LAFAYETTE HOME HOSPITAL, INC., ANESTHESIOLOGY ASSOCIATES, P.C., JOHN WALLING and KENNETH J. BOCHENEK, M.D.,	)	
Defendants.	)	

ORDER

The Court, having received Plaintiff's Motion for a Jury Trial and for Leave to File a Jury Demand Pursuant to Federal Rules of Civil Procedure 39(b) and 6(b) and Defendants' Objection to Plaintiff's Jury Demand, all parties having been given due notice, and the Court being duly and fully advised in the premises,

IT IS THEREFORE ORDERED:

1. Defendants' Objection to Plaintiff's Jury Demand is hereby **denied**; and

2. Plaintiff's Motion for a Jury Trial and for Leave to File a Jury Demand Pursuant to Federal Rules of Civil Procedure 39(b) and 6(b) is hereby **granted**.

Dated: 5/28/02

/s/ Allen Sharp
Judge Allen Sharp

cc: all counsel

UNITED STATES COURT OF APPEALS

For the Seventh Circuit
Chicago, Illinois 60604

October 6, 2006

Before

Hon. MICHAEL S. KANNE, *Circuit Judge*

Hon. TERENCE T. EVANS, *Circuit Judge*

Hon. ANN CLAIRE WILLIAMS, *Circuit Judge*

No. 05-1196

CAROLYN G. KOCHERT, M.D.,
Plaintiff-Appellant,

v.

GREATER LAFAYETTE HEALTH SERVICES, INC., doing business as LAFAYETTE HOME HOSPITAL doing business as ST. ELIZABETH MEDICAL CENTER, JOHN WALLING and ANESTHESIOLOGY ASSOCIATES PC,
Defendants-Appellees.

Appeal from the United States District Court for the Northern District of Indiana, Hammond Division.

No. 01 CV 27

Allen Sharp,
Judge.

ORDER

On consideration of the petition for rehearing and petition for rehearing en banc filed by plaintiff-appellant Carolyn Kochert on September 25, 2006, no judge in regular active service has requested a vote on the petition for rehearing en banc, and all of the members of the original panel have voted to DENY the petition for rehearing.

Accordingly, the petition for rehearing is DENIED.

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF INDIANA
HAMMOND DIVISION AT LAFAYETTE

CAROLYN G. KOCHERT, M.D., Plaintiff	)	
v.	)	Civil Case
GREATER LAFAYETTE HEALTH SERVICES, INC., d/b/a ST. ELIZABETH MEDICAL CENTER and d/b/a LAFAYETTE HOME HOSPITAL, INC., ANESTHESIOLOGY ASSOCIATES, P.C., JOHN WALLING and KENNETH J. BOCHENEK, M.D. Defendants	)	No. 4:01 CV 0027 AS

EXPERT WITNESS REPORT OF
BRUCE A. SEAMAN, PH.D.

* * *

case. The first in August 1994 involved LHH (represented by John Walling) and AA (represented by Kenneth Bochenek), whereby AA agreed to schedule and provide all anesthesia services at agreed upon fees for surgery and obstetrics for LHH for a period of two years in exchange for being the exclusive provider of anesthesia services during the term of the agreement. In 1994, Plaintiff and other non-members of AA entered into a subcontract with AA to provide anesthesiology services at LHH. At the time the initial exclusive agreement was made between LHH and AA, and at the time of renewals (apparently not open to competitive bidding) in 1996 and 1998, St. E's was independently operating in Lafayette, providing both

general surgical and obstetrical services requiring (and allowing) the services of anesthesiologists in the area who were not members of AA, including the Plaintiff. The second primarily background agreement was the May 29, 1998 contract between St. Elizabeth Medical Center and Lafayette Anesthesiology (LA), whereby LA (including the Plaintiff as a member) became the exclusive provider of all anesthesia services for three years through May 31, 2001. This agreement also set forth a fee schedule for LA's services. Thus, as of mid-year 1998, there were two major independent hospitals providing surgical and obstetrical services in Lafayette, each providing anesthesia services via exclusive contracts with a different anesthesiology physician group. At the time of the filing of the *Amended Complaint,* Lafayette Anesthesiologists had eight physician members; Anesthesiology Associates had fourteen physician members. There may have been as many as twenty-five anesthesiologists serving the Lafayette area at the time the initial exclusive contracts were signed.

11. However, it is events supplemental to these initial contracts that are of special interest to the antitrust claims raised in the *First Amended Complaint.* Firstly, upon the expiration of the subcontract between Plaintiff and AA in March 1998, her contract was not renewed by AA. Furthermore, after March 1998 neither Dr. Kochert nor other doctors with Lafayette Anesthesiology have renewed or sought sub-contracts with AA allegedly due to differences on issues of training, patient care, partnership management, price of services, personal conflicts, and for other possible reasons including warnings from individual counsel that such sub-contracts could have antitrust implications (e.g. Farrell Deposition, pp.133-134) Thus, after March 1998, despite having medical privileges at

LHH, the anesthesiologist members of LA, including at that time the Plaintiff, have not been able to perform general anesthesiology services (other than non-surgically related pain management) at LHH. Similarly, anesthesiologists (including the Plaintiff and Drs. Conrad and Farrell among others) affiliated with Unity Health Care (located on Creasy Lane in Lafayette), whether members of LA or not, have not been able to exercise their clinical privileges at LHH (e.g. Eberle Deposition, 04/14/03, p. 20, lines 2-8, related also to the same issue at St. Elizabeth Medical Center at a later date; see below).

12. Secondly, the potential adverse impact of the exclusive anesthesiology contracts on surgical and obstetrical patients within the Lafayette area was heightened by the organizational change (sometimes called a merger), effective approximately January 1999, whereby Lafayette Home Hospital and St. Elizabeth Medical Center became owned and controlled by Defendant Greater Lafayette Health Services (GLHS). This was followed by the third development on or about April 7, 1999, when GLHS closed the labor and delivery unit at St. Elizabeth Medical Center and transferred all such medical services to Lafayette Home Hospital. Therefore, following April 7, 1999, Plaintiff and other LA members (and subsequently Unity Health Care affiliated anesthesiologists whether members of LA or not, including the Plaintiff) were limited to providing anesthesiology services for non-obstetrical surgeries at St. Elizabeth's Medical Center (or potentially other medical facilities in the area providing surgical services), since there no longer were any general obstetrical procedures, most notably the delivery of babies, taking place at the

* * *

and AA in the anesthesiology market, is not significantly affected by considering a local market of Tippecanoe plus the seven contiguous counties as an alternative. A very strong case can be made that the relevant geographic market for obstetrical hospital services, and for inpatient surgical services is in fact no larger than Tippecanoe County, and it is my professional opinion that the most relevant geographic market for determining the degree of market power of both the GLHS hospitals and the AA group of anesthesiologists is Tippecanoe County.

c. The four county geographic market is quite similar but not identical to the U.S. Census Bureau's definition of the Lafayette, Indiana Metropolitan Statistical Area (MSA), number 29140, which consists of Tippecanoe, Benton, and Carroll counties. It is also similar to the Census Bureau's definition of the Lafayette-Frankfort Consolidated Statistical Area, which simply adds Clinton County to the above three counties. Therefore, while the term "Greater Lafayette Metropolitan Area," cited in the *Amended Complaint* may lack precision and not be commonly used by everyone in the region, the substance of the opinion that the relevant geographic market is local and linked to the Lafayette metropolitan statistical area is in fact confirmed by a thorough economic analysis. In fact, as noted above, the most relevant geographic market for evaluating the claims in this case is even smaller than that MSA area, consisting of Tippecanoe County itself.

d. Based on these relevant product and geographic markets, the two GLHS operated hospitals do in fact have a substantial market share of hospital services in several alternative geographic markets. The 2001 combined LHH and St. E's market share is 91.54% for all admissions (omitting psychiatric admissions) in a Tippecanoe County

market, 85.62% for inpatient surgical procedures in a Tippecanoe market, and 97.7% for obstetrical admissions in a Tippecanoe market. That market share is 74.7% in a four county OB market including Tippecanoe, Montgomery, Clinton and White Counties (76.0% if expanded to an eight county market of Tippecanoe and all contiguous counties), and 61.64% for inpatient surgical procedures in the four county market (62.31% if expanded to the eight county market). Furthermore, AA has considerably greater than the 20 percent of the market for anesthesiologists identified as a "safety zone" standard by the joint Department of Justice and Federal Trade Commission health care guidelines for evaluating exclusive joint provider contracts. The actual market share is about 50%, if AA is considered to have only 15 members (not counting two *locum tenens* and one doctor under subcontract). Since those three anesthesiologists are under contract to AA, considering them a part of AA raises its market share to about 60%.

e. While market share alone is not identical to market or monopoly power (e.g. Landes and Posner,1981), the two GLHS hospitals have significant market power in the Tippecanoe market for hospital obstetrical patients, and more limited market power in the four-county local market for inpatient surgical patients. Anesthesiology Associates (AA) has market power in the provision of anesthesia services in support of obstetrical procedures in the Tippecanoe market, and also in the four county market for anesthesia services in support of inpatient surgical procedures.

f. Due to the absence of effective competition in the relevant market from other organized and experienced anesthesiology groups, and the very limited effective

hospital alternatives facing obstetrical and to a lesser extent surgical patients requiting admission exceeding twenty-three hours, hospital patients and their third party payers cannot realistically protect themselves from higher anesthesia prices, lower quality of anesthesia services or diminution of effective consumer choice without incurring excessive travel and related costs in order to seek more distant medical care alternatives. Hence, the exclusive contracts and related acts by Defendants causes antitrust injury to identifiable consumer groups worthy of protection under the antitrust laws. *Affidavits* from medical care consumers indicating that they were precluded from receiving anesthesia from the Plaintiff, and other *Affidavits* from medical personnel and family members of patients indicating serious concerns about the quality of anesthesia care being provided by AA, is one indication that the contracts and related acts at issue have already been having adverse effects on consumers in the relevant market. Furthermore, since the requirements under the exclusive contracts to both LHH and St. E's hospitals have made it effectively impossible for AA anesthesiologists to provide services at other local market hospitals, competition with GLHS hospitals from those other area hospitals has been weakened as their access to anesthesiologists has been effectively restricted in a manner similar to what economists have called "raising rivals' costs."

g. There is direct evidence in the record (from GLHS administrative officials) that GLHS would strongly prefer to contract with local anesthesia groups having physicians who have experience with their facilities, have had privileges at their hospitals, and are familiar to their surgeons. There are at least 21 alternative anesthesia groups to AA located in Indiana, but only one (LA) which is local and

meets those criteria, but whose membership has been limited by the lack of available anesthesia options in any of the alternative geographic market definitions identified above. By contrast, 20 of these groups are located from about 1.10 hours to 2.90 hours from Lafayette, and do not provide a viable competitive check on AA as the dominant provider of anesthesia services in the relevant market. The existence of individual independent or *locum tenens* anesthesiologists who travel longer distances, and the recruitment of an occasional individual anesthesiologist to become a member of either AA or LA in the local market, does not contradict the conclusion that the effective anesthesiology labor market is local. A situation in which there are only two competing anesthesia groups in a relevant market has been challenged by the Department of Justice Antitrust Division (in a business review letter related to an Orange County case) as providing inadequate competition and inducements to maintaining high quality care, a situation with strong similarities to the instant case.

h. There is no evidence in the record that the anti-competitive risks and past restrictions on effective consumer choice, and the possible reductions in the quality of care resulting from market power in either the hospital services market or the anesthesiology labor market, are counterbalanced by significant (or any) cost savings, enhanced quality of patient care, or other pro-competitive effects uniquely stemming from the exclusive contracts between GLHS and AA. In fact, the record suggests a reduction in the quality of care provided to anesthesia patients, and that the total quantity of anesthesiologists available to provide adequate quality of care in the relevant market continues to be problematic (e.g. Eberle Deposition, p. 124). Whether anesthesia prices have been

made higher as a result of the alleged unlawful acts in this case is difficult to ascertain. However, there is evidence that such higher prices exist (with testimony in the record indicating that as of February 2003, the AA rate per unit was $56, higher than any other known rate in either Tippecanoe County, or the possible four or eight county alternative market areas), and at least no evidence that anesthesia unit prices are lower in the relevant market as a result of the exclusive contracts and related acts identified in the *Amended Complaint.*

i. Finally, it is my opinion that Dr. Kochert is a relatively efficient enforcer of the antitrust laws in this particular case. Without doubt there are common situations in which an alternative supplier would not be a credible party to an allegation of anti-competitive conduct by other suppliers, since such conduct, if really anti-competitive rather than efficiency enhancing, would increase prices and/or restrict effective output to the ultimate benefit of the complaining supplier. Thus, economists would lend little credence to a complaint by Jet Blue that a merger between United Airlines and Continental Airlines would have anti-competitive effects on the Chicago to Atlanta commercial aviation route, since Jet Blue could only benefit from such effects (thus suggesting that Jet Blue's real fears may be that the merger would have pro-competitive consequences). However, economists would not so easily dismiss a Jet Blue complaint that United had conspired with Chicago O'Hare Airport to limit its access to quality gate locations, or assign it inconvenient take-off and landing slots, since such behavior could credibly deny air passengers effective access to a high quality, possibly lower priced airline. Furthermore, the Landes and Posner (1977) justification of the *Illinois Brick* ruling denying antitrust standing to indirect purchasers

was fundamentally based on the view that economic agents who are farther removed from the decision-making nexus have a more complex task of establishing a causal connection between a particular market result and its underlying cause, hence making them less efficient and higher cost enforcers of the antitrust laws. This logic can be extended to argue that an excluded potential supplier is better able to identify the potentially anticompetitive behavior and effects of particular contractual arrangements and related behaviors than are medical care consumers, especially if one views the consumers as the patients themselves. Third party-payers including managed care plans are clearly better able, and have greater financial incentives, to monitor the potentially anticompetitive effects of physician group contracts with hospitals than do the patients themselves. However, this does not imply that excluded suppliers, such as the Plaintiff in this case, cannot be efficient enforcers of the antitrust laws, and state and federal government antitrust agencies commonly serve as efficient enforcers even though they are not direct consumers.

G. OPINIONS: DETAILED DISCUSSION

Product Market Issues

31. Product market definition requires an assessment of the degree to which potential substitute goods or services are sufficiently close substitutes so as to provide effective consumer choice that protects consumers from price increases and reductions in product quality. An important concept is the cross price elasticity of demand, defined as the percentage change in the

* * *

this case the two GLHS hospitals). Again, this finding is consistent with the potential bias regarding the potentially erroneous finding of a relatively large geographic market that is recognized in the academic literature that warns against naive interpretations of relatively low LOFI (export) results stemming from an analysis of patient admissions data.

57. Furthermore, as already identified in the opinions summary (paragraph 30d), the resulting market shares of GLHS hospitals in a Tippecanoe only market are:

a. 91.54% for all hospital admissions (excluding psychiatric procedures)

b. 85.62% for inpatient surgical admissions

c. 97.7% for obstetrical (OB) admissions

These market shares can be calculated from the detailed hospital and county data provided in Exhibit H.

Table 5

Market Definition: Tippecanoe, Montgomery, Clinton and White Counties

	All Admissions		OB Admissions		Inpatient Surgical Admissions	
	LIFO	LOFI	LIFO	LOFI	LIFO	LOFI
2001	82.48	78.98	91.32	81.30	71.87	74.48
2000	82.78	78.61	91.74	80.70	74.28	73.97
1999	83.31	78.42	91.34	80.37	74.06	74.36
1998	82.91	77.42	91.06	79.33	71.37	73.18
1997	83.11	77.32	90.36	79.40	71.97	72.62

58. Since the procedure for determining relevant antitrust markets is to begin with the smallest potential market and continue to expand the market definition until a market definition can be analytically justified, a further analysis of the relevant geographic market for hospital services

* * *

Market Power and Antitrust Injury

64. The currently recognized two-pronged test for unlawful monopolization under Sherman Section 2 was established by the Supreme Court in its *Grinnell* decision (*United States v. Grinnell Corps.,* 384 U.S. 563, 570-571, 1966):

"The offense of monopoly under Section 2 of the Sherman Act has two elements: (1) the possession of monopoly power in the relevant market and (2) the willful acquisition or maintenance of that power as distinguished from growth or development as a consequence of a superior product, business acumen, or historic accident."

Typically, in order for market conduct to be considered anticompetitive or exclusionary, it must meet two basic criteria: (1) "the conduct must be other than that encouraged by and consistent with the competitive process" such as product innovation or nonpredatory prices reductions; and (2) "the conduct must also be substantially related to the maintenance or acquisition (or attempted acquisition) of monopoly power, in that it must have (or be expected to have) the effect of destroying or excluding competition" (the quoted passages are from Fisher, McGowan and Greenwood, 1983, p. 272). Exclusionary conduct has been defined in a similar way as "conduct, other than competition on the merits or restraints reasonably 'necessary' to

competition on the merits, that reasonably appear capable of making a significant contribution to creating or maintaining monopoly power" (Areeda and Turner, section 626g; see also Landis and Rolfe, 1985).

65. The relevant issues are whether high market shares indicate monopoly market power, and whether such market power is the result of, and is being maintained by exclusionary behavior as opposed to being the "consequence of a superior product, business acumen, or historic accident" (*Grinnell*). As derived above, GLHS has significant market shares in the local market for inpatient hospital and obstetrical services, particularly in the Tippecanoe market. Market share is one, but not the only consideration in evaluating market power (see, e.g. Landes and Posner, 1981). Where barriers to entry are low and effective entry is possible with minimal time lags, high market share will not translate into an ability to maintain supercompetitive prices, restrict output and earn above normal economic profits. In the market for inpatient hospital surgical services and hospital obstetrical services, it is customary to presume that entry is difficult and protracted, since it is relatively uncommon for new hospitals to be established, and the governmental regulatory restrictions in the hospital industry are relatively significant. Furthermore, as noted by Simpson and Coate (1998), one way in which physician-hospital contracting can generate anticompetitive effects is by raising rivals' costs of doing business by tending to exclude physicians from practicing at competing hospitals. In this case, while AA provides a significant share of the anesthesiologists available to hospitals in the Lafayette area, the demands of the exclusive contract between AA and GLHS have, at least *de facto,* precluded any AA affiliated anesthesiologist

from providing services at any other area hospitals. Those hospitals were already shown above to be relatively weak competitors to either LHH or St. E's, so any additional competitive disadvantages that they face can only serve to further strengthen the market power of GLHS. This is one potential financial advantage to GLHS from the exclusive contracts that does not seem to have any plausible pro-competitive or efficiency enhancing effects. There is little evidence of such efficiency benefits in any case, as discussed below in paragraphs 71 and 72.

66. Furthermore, there is considerable evidence in the record in this case that adverse effects are being suffered by patients in this market in the form of a diminution of the quality of care. The extensive list of filed affidavits identified above, in which patients and in many cases medical personnel have reported AA anesthesiologists absent from operating rooms during anesthesia procedures, or asleep during such procedures, and the deposition testimony of Drs. Summer, Farrell, Eads, Moranda, and Potts, along with the testimony of Tracy Graham provide significant evidence that AA has been providing lower quality of care than might otherwise be expected in a more competitive market. The expert affidavits of anesthesiologists Drs. Ivankovich, Williams, and Minore are especially compelling regarding relevant to the issue of a reduced level of quality of care, and hence implicitly an increase in the effective price of anesthesia services in the relevant market. Hence, there is both the plausibility of antitrust injury in this case, and actual evidence of such injury in this case. The fact that another large group of people have been willing to file affidavits indicating that they have been aggrieved by a reduction in their effective choice of an anesthesiologist such as Dr.

Kochert, is further evidence of consumer harm as a result of the behavior of the defendants.

Leveraging and Essential Facilities

67. The issues of leveraging monopoly power from one market to another, the strategy of "raising rivals costs," and the degree to which a competitor is obligated to deal with a competitor in the provision of what might be called an "essential facility" have been controversial topics in antitrust law and economics. However, as is common in the evolution of economic analysis, various principles have become generally established for the evaluation of these issues.

68. Monopoly leveraging refers to the exploitation of monopoly power in one market to extend that market power into another market. The most familiar strategies are (1) tying arrangements and bundling, (2) vertical price squeezes, (3) price discrimination, and (4) service or quality discrimination (e.g., see David L. Kaserman and John W. Mayo, 1993). Economists have long debated the circumstances under which such strategies can plausibly increase profits and

* * *

Potentially undesirable results from such exclusive contracts have also been identified by industry publications (e.g. "Exclusive Contracting With Your Hospital," *The Hot Airway For the Business of Anesthesia,* Fall 1998).

71. While there is considerable discussion in the depositions of Mr. Walling and Eberle as to their potential motivation for turning to exclusive contracts to improve scheduling, ensure adequate call coverage, and encourage

optimal contracting with GLHS managed care customers, there has been surprisingly little evidence of any cost savings, or any attempt by GLHS to encourage such better performance by insisting on competitive contracting during contract renewal periods (which has not been done during any of the contract renewal periods). In fact, the following section of the Eberle Deposition of 04/14/03 (p. 177, II:5-15) is indicative of the lack of compelling evidence of real efficiencies stemming from these exclusive contracts:

Eberle: The efficiencies would be related to the publishing of the anesthesia schedule, the scheduling of cases, and in the anesthesia areas on both campuses the fact that there is one contract holder to turn to if there are any issues to deal with. One person does the schedules for both hospitals. Those are the real efficiencies.

Question: Can you measure that in cost savings – dollar amounts?

Answer: No, never attempted to.

Question: And can you measure the improved coordination in terms of dollar amounts? Answer: Not in terms of dollars, no. But in ease of running the schedule and lack of frustration and smooth operation, yes.

While this does not prove that such efficiencies do not exist, it hardly serves as an effective counterweight to the anticompetitive risks created in the relevant market in this case as a result of these contracts. Government antitrust policy has stated that the greater the competitive risks, the greater the counterbalancing efficiencies (cited above). There is no real evidence in this case to suggest that the efficiency gains are substantial enough to meet

that test, nor that other less potentially anticompetitive approaches to solving any scheduling problems could not have been found.

72. Finally, it has always been recognized in cases such as this that one normally would expect to find the hospitals with a compelling economic interest that would be consistent with improving the quality of patient care, and providing it at lower effective prices. That is, it would normally appear that hospitals' self interest correlates strongly with ultimate consumer self interest in ensuring that high quality, low priced care is provided by any physician groups contracting with the hospitals. It has already been suggested that a potential non-competitive interest of GLHS may have been to restrict the availability of anesthesiologists to competing hospitals (and by extension to surgical centers competing with GLHS in outpatient surgeries). However, it is unclear that this would provide sufficient self-interest to override the considerable evidence in the record that the quality of patient care has been compromised by the exclusive utilization of AA at GLHS facilities. Whether this is merely the result of an absence of effective administrative oversight is unclear at this time. However, the record remains that such adverse effects have been occurring in this market.

* * *

Table 4: Market Definition: Tippecanoe County*

	All Admissions		OB Admissions		Inpatient Surgical Admissions	
	LIFO	LOFI	LIFO	LOFI	LIFO	LOFI
2001	91.45	57.56	97.70	62.76	85.62	52.21
2000	91.53	56.81	97.86	61.35	86.77	50.96
1999	91.42	56.04	97.15	61.12	86.45	50.25
1998	91.33	55.85	96.93	61.43	84.47	51.04
1997	91.39	55.47	97.47	61.39	84.38	49.64

Table 5: Market Definition: Tippecanoe, Montgomery, Clinton and White Counties*

	All Admissions		OB Admissions		Inpatient Surgical Admissions	
	LIFO	LOFI	LIFO	LOFI	LIFO	LOFI
2001	82.48	78.98	91.32	81.30	71.87	74.48
2000	82.78	78.61	91.74	80.70	74.28	73.97
1999	83.31	78.42	91.34	80.37	74.06	74.36
1998	82.91	77.42	91.06	79.33	71.37	73.18
1997	83.11	77.32	90.36	79.40	71.97	72.62

Table 6: Market Definition: Tippicanoe County Plus 7 Contiguous Counties*

	All Admissions			OB Admissions			Inpatient Surgical Admissions		
	LIFO	AVG.	LOFI	LIFO	AVG.	LOFI	LIFO	AVG.	LOFI
2001	81.81	87.16	92.50	90.94	92.88	94.82	71.14	80.70	90.26
2000	81 76	87.01	92.25	90.60	92.12	93.64	72.94	81.21	89.47
1999	82.34	87.35	92.35	90.56	92.56	94.56	72.88	81.20	89.52
1998	81.80	86.69	91.57	90.36	92.34	94.31	70.39	79.80	89.20
1997	81.96	86.65	91.34	89.47	91.77	94.07	71.12	80.06	88.99

Rockford Memorial*
(D.C.)

LIFO	LOFI	AVG
93%	71-75%	82-84
85%	79%	81.9%
80%	83%	81.5%
81.4%	86.8%	84.1
77%	88%	82.5%
74.7%	90%	82.4

Market Share/Monopoly*
GLHS/Tippecanoe Country

All Admissions	91.54%
Inpatient Surgical	85.62
OB	97.7%

4 County:

Inpatient Surgical	61.64%
OB	74.7%

8 County:

Inpatient Surgical	62.3%
OB	76%

*Reproduced from Exhibit M to Supplemental Brief in Opposition to Defendants' Motions for Summary Judgment, R. 406.

IN THE UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF INDIANA
HAMMOND DIVISION AT LAFAYETTE
CAUSE NO. 4:0ICV0027AS

CAROLYN G. KOCHERT, M.D.,

Plaintiff,

-vs-

GREATER LaFAYETTE HEALTH SERVICES, INC., d/b/a ST. ELIZABETH MEDICAL CENTER and d/b/a LaFAYETTE HOME HOSPITAL, ANESTHESIOLOGY ASSOCIATES, P.C., JOHN WALLING, and KENNETH BOCHENEK, M.D.,

Defendants. /

DEPOSITION OF BRUCE A. SEAMAN, Ph.D.
Tuesday, January 28, 2004
9:03 a.m. – 5:40 p.m.

1325 Virginia Avenue
Atlanta, Georgia

* * *

[22] And since it's my view that the primary competitive constraint imposed on anesthesiology groups are provided primarily by local anesthesiology groups, the weakening of that alternative constraining influence has allowed this quality of care issue to persist in a way that would not likely have persisted had there been the continuation of the exclusive contract with LA at St. E's or even perhaps

just using an open staff system and not having any exclusive contracts at all.

So I would say that in general, the anesthesiology market has been adversely affected in terms of quality of care in a way that would not have otherwise happened had GLHS not chosen to set up its contracts in a way that it has.

Q. All right. Other than eliminating the exclusive contract of LA at St. E, which occurred effective June 1, 2001, is there anything else that, in your opinion, GLHS did to exercise market power in a way that would harm competition?

A. I think, consistent with my report where I set up the background, I identified an individual exclusive contract as in and of itself not anticompetitive; it's looking at the context.

We have, of course, the sequence of events [23] starting with the March 1998 denial of the renewal of the subcontract with Dr. Kochert, followed by the closing of the OB unit.

And then, in my view, as I stated in the report, those are sort of sequential events that led then ultimately to the primary concern that I have, that given those prior events, it made that 2001 contractual arrangement much more likely to have the kind of anticompetitive effects that I mentioned a moment ago.

So it's really a matter of looking at these events as a sequence of events that, when combined, creates anticompetitive concerns that might not have been as present had those three events not been combined.

So I think you're correct that I certainly, in my report, did focus primary attention on the 2001 issue of extending the exclusive contract to AE to include also St. E's as well as LHH. The effects of that have to be viewed in the context of the prior two events.

Q. Wouldn't it be correct, Dr. Seaman, that those two prior events by themselves did not cause any antitrust injury or cause any harm to competition?

A. I think that's – I think you could view my [24] report as consistent with that view, that I looked at those as essentially individual events when viewed in isolation as not in and of themselves causing any major anticompetitive concern.

If you look at the three events together, that's what causes me concern.

Q. Would you agree, then, Dr. Seaman, that Dr. Kochert did not sustain any antitrust injury in 1998 when AA decided not to renew her subcontract with AA?

A. Well, my view of this case – I don't mean to give a rambling answer. I know that you want a yes or no answer, and I appreciate that. I just want to make this clear, though. I have always agreed, I think, with defense experts on this, Drs. Eisenstadt, Heiden, Liang, that this case cannot easily be answered or evaluated solely in terms of Dr. Kochert.

I've always viewed this case in terms of its economic consequences as broader than Dr. Kochert – she is the named plaintiff clearly – but that the case, in terms of anticompetitive consequences, does, in fact, extend to damage to competition, not just damage to a single competitor. I've always viewed it that way. And that even

though there were not other named plaintiffs, I think that the issues go beyond [25] Dr. Kochert.

So that even though in 1998 there was a particular contractual issue with her and AA that initially led her to file a suit, it also led to other contractual negotiations with other members of LA at the time, which caused other problems with subcontracting and then led to a whole sequence of events, which then further weakened LA as a competitive force.

So again, I don't mean to make this excessively fine as a distinction, but my own view of the case is that Dr. Kochert is, by antitrust standards, an efficient enforcer of the antitrust laws, but that the issues raised in this case go well beyond her individually as a particular competitor to a broader issue of the competitive issues at stake here with anesthesiology groups.

Q. Dr. Seaman, in Dr. Kochert's Memorandum in Opposition for Defendant's Rule 12 Motion to Dismiss, which was filed in this case on December 4, 2001, Dr. Kochert makes the following statement on page 38 of her brief: "Because two separate hospitals had anesthesiology services, there was not an anticompetitive effect to the market as a result of Dr. Kochert alone being barred from practicing only at

* * *

[161] Q. You have made several references both today and in your previous testimony to the cellophane fallacy?

A. Yeah.

Q. In order to really apply that concept to this case, wouldn't you have to do a dynamic test to measure the exercise in market power both pre and post June 1, 2001.

A. Remember – well, I'd say not necessarily because of the context in which I used the fallacy. Let me clarify briefly. I'll be brief.

You, obviously, had asked me a question about whether I was defining the market properly. It was in that context that I had always said –

Q. I understand.

A. My answer would be that, in that context, I was simply saying that it would be inappropriate to say that if a person could, let's say, go far and wide to evade a problem that that would automatically mean that it was a [162] regional or large scale market area, geographic area –

Q. I understand. My question is: If you're suggesting that there's been this exercise of market power, wouldn't we have to do some type of dynamic test – some time study based test to show that market power has changed both before and after the antitrust injury?

A. I think it goes back to your question about what the – you know, what's the evidence about the quality issues that are at stake in this case and is there – what's the nature of the evidence regarding the timing, the severity.

I tried to answer that to the best of my knowledge earlier, that as far as I can tell there's been a pervasive problem, that it seems to not be diminishing and I don't at the moment have a very – especially given, I think, some

of the reporting difficulties that might have occurred that I referred to earlier in terms of who's there to even report these things now without a conflict of interest arising, that I [163] don't have great evidence of – but I'm not sure that that doesn't mean that it has been increasing.

Q. You haven't attempted to do any such study, correct?

A. That's – except for sort of trying to have a general idea about what the dates are in those affidavits, no, I haven't. Right.

Q. Is there any other way that we could determine that GLHS has actually exercised market power after June 1, 2001?

A. Whether it's after 2001 or whether it's back early of the '98 period or any of those periods which are at issue here, because the whole sequence of events that really causes the issue here, I'd say it's – I mean, one way would be to sort of see whether the problem has gotten more severe in terms of the quality adjusted pricing. That would be one issue, I think.

Q. Would there be any other way?

A. Another way could be if you were to do [164] a pricing study that would sort of predict what would have happened to prices without market power versus what actually happened to market prices. That is standard. I've done those myself in price fixing cases, for example. That's one way to do it.

There could be some other kinds of issues in terms of severity of harm, in terms of surgeons complaining or something. There's been – of course, we know there have

been some surgeons who have complained in this case about those issues.

Q. Again, you haven't done that kind of study either, correct?

A. I've monitored carefully the evidence as it's been portrayed in the depositions because that serves as the factual foundation for this.

My knowledge of these issues, of course, is not as a physician but someone trying to observe what the factual record is.

Q. You talk in your report about the risk

* * *

[139] you asked right at the outset today, really, about what do we know about any real quality controlled increase in price because, again, economists measure market power not as market share, but that's one factor. I mean, you know, you can relate market power to market share, but it is not a direct translation.

And if you are asking about the standard triumvirate, quantity reduction, price increase or quality reduction, I think we know the following, that there is slightly higher nominal prices which are the contracted prices – not the contracted prices, but the so-called list prices with AA versus, say, LA. But far more importantly, there are this – I think higher prices in terms of a quality controlled situation.

When you ask that hypothetical – well, if you did that what is the pay standard I discussed earlier, what would somebody be willing to pay if they were aware of these conditions instead of what they were actually [140] paying,

I think you would find a substantial higher price. That would be the indication of market power.

Q. You would measure market power with respect to AA and GLHS in the same manner?

A. Well, I think the greatest example of market power by that standard has been in the specifics of the quality of care for anesthesiologists.

Of course, the hospital is providing this integrated service, which is the hospital services complimented with the anesthesiologists to supply either a baby delivery or a kidney transplant. And so, in that context, the hospital cannot be viewed as a totally – you know, cannot be excluded from this problem.

I mean, independent of any issue about Professor Gertler's own analysis that suggests that at least in similar type markets you can have as much as 13 to 26 percent higher prices in hospitals like that. That was the result of his study and I'm saying it is potentially [141] applicable to this market.

I'm saying that the hospital certainly when it is actually providing hospital based services, it cannot be viewed as independent of that quality problem because it is a quality problem that exists on its premises with its product.

Q. Wouldn't you be over measuring the effect of this market power if you factor in that price differential both with respect to AA's prices and the hospital's prices?

A. I would agree potentially, potentially.

Let's just put it this way, we could probably get to an easy 20% overpricing by giving each one 10% of it.

Q. Is that your opinion?

A. I take your point as well taken. And I would be cautious to just simply throw, you know, some ridiculous number.

I'm saying I think it's clear if patients were informed about this, they would [142] view that as a diminution of quality and would translate into a higher effect price and how you parse that between the two entities does not change the fact that there is, in fact, a higher quality controlled price and it's not attributed back into it.

Q. One way of evaluating that differential effect on price would be to try to calculate the number of procedures where this diminished quality of care by leaving the operating room, or whatever it is, has actually occurred?

In other words, take the total universe of procedures and try to calculate the number of times this has happened and come up with some number?

A. Again, potentially consistent. Although, I want to couch this correctly. First of all, of course, there can be underreporting of actual incidence. This is always a possibility.

I don't want to be on the record of [143] saying that my view of how often it occurs is limited solely to the number of times a particular person has come forward, because it's not a trivial thing to come forward and complain about that. I think that's something that's in evidence.

I would also say what you're really dealing with here is a variation on my theme. Let's say that it occurs in 5% of the cases. Then you would ask a potential patient, what would you be willing to pay if I told you that you have a 5% chance of being subjected to life-threatening harm because of this kind of behavior?

And I would agree with you that that is certainly going to be a – not as dramatic a lower willingness to pay or required compensation back to accept that risk than if somebody were told, you have 100% chance somebody is going to be eating a sandwich while you're unconscious.

I think that's clear, but it [144] doesn't – you know, it's really a matter of degree. I agree.

Q. So wouldn't it be fair to say then that the differential price effect, as you have termed it, is also a matter of degree to that same degree?

A. Of course, degrees matter in economics. Degrees matter when you talk about anticompetitive harm.

And one of the things that's debated by economists is whether some of the thresholds that the interested agencies use may be too generous or not generous enough or too strict or not strict enough.

You have to remember when you make that point – it's a very good point. But it's one that you have to remember, too, when I said what would somebody be willing to pay or how much would you have to accept, when I gave my answer about maybe 20% diminution, I was actually not trying to push the point.

In reality, I could have said – could [145] have easily said that if somebody were told that you were certain to be

put at this risk, somebody would probably say, I wouldn't pay a dime, I wouldn't pay a penny to go in there. So that would be a complete elimination of value. Or somebody might easily say, you couldn't possibly pay me enough to accept that risk.

If we're in that realm now, then, obviously, making the adjustment that you make is perfectly appropriate, but we're coming now from clearly elevated numbers like – and even now making that proportional adjustment, it would probably still be very big effective price increases.

Q. But you don't really have any way of quantifying it at this point; isn't that right?

A. I would ideally perhaps like to do some kind of survey of asking people or something and give them this – somewhat similar to what contingent valuation studies on environmental protection study, how much do you value this or how much would you need to be paid

* * *

AFFIDAVIT OF PROFESSOR PAUL J. GERTLER

If called to testify under oath, I would state the following to the best of my ability, recollection and expertise.

1. My name is Paul J. Gertler, and I am a Professor of Economic Analysis and Policy, at Haas School of Business, University of California, Berkeley. My credentials are reflected in my Curriculum Vitae, a copy of which is attached to this affidavit as Exhibit "A."

2. I have been retained by the law firm of Kamensky & Rubinstein in a case filed by Dr. Carolyn Kochert against Greater Lafayette Health Services, Inc. and others in the federal court in the Northern District of Indiana, Hammond Division at Lafayette, Cause No. 4:01 CV 0027AS. My hourly charge is $450.00 for this retention.

3. My opinion for this case is that there is no evidence from research which I have conducted, and in which I have participated, that exclusive relationships between doctor groups and hospitals for the provision of medical care and services produces cost-savings or an improvement in quality of medical care and treatment provided to consumers by such exclusive arrangements, except in the case of non-profit teaching hospitals in large metropolitan areas. Further, such arrangements have little effect on efficiencies, but is associated with an increase in prices, especially when the arrangement is exclusive and occurs in less competitive markets. The market for the two hospitals in Lafayette, Indiana is an example of a less competitive market and would reflect markets which have been the subject of my research and study.

4. My opinions are based upon my expertise, background, research and study, and are, as well, reflected in a research paper entitled, "Strategic Integration of Hospitals and Physicians," which is attached to this affidavit as Exhibit "B."

5. I have not testified either in depositions or at trials as an expert witness within the last four years.

FURTHER AFFIANT SAYETH NOT.

/s/ Paul J. Gertler
Paul J. Gertler, Ph.D.

Date: August 25, 2003

SUBSCRIBED and SWORN to before me
this 25th day of August, 2003.

/s/ [Illegible]
Notary Public

[SEAL] **BERTHA P. SOTO**
Commission # 1375714
Notary Public – California
Alameda County
My Comm. Expires Sep 20, 2006

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF INDIANA
HAMMOND DIVISION OF LAFAYETTE

CAROLYN G. KOCHERT, M.D., Plaintiff, vs. GREATER LAFAYETTE HEALTH SERVICES, INC., d/b/a ST. ELIZABETH MEDICAL CENTER and d/b/a LAFAYETTE HOME HOSPITAL, ANESTHESIOLOGY ASSOCIATES, P.C., JOHN WALLING and KENNETH BOCHENEK, M.D., Defendants.	)	No. 4:01CV0027AS

DEPOSITION OF PAUL J. GERTLER, PH.D.

Berkeley, California

Friday, February 6, 2004

* * *

[58] vertical relationships are not a good thing?

MR. ZAREMSKI: Objection. It goes way beyond the opinions of Dr. Gertler presented in this report and in his Affidavit.

THE WITNESS: What I can say is that when hospitals and physicians engaged in closed hospital organizations and management services organizations and in open physician hospital associations, we tend to see price increases without improvements in cost and quality.

And so that leads to increased profits for those organizations and increased price premiums, insurance premiums for consumers. They seem to have no effect on the looseness form of organization. And we do see some benefits of the fully integrated organizations, and those seem to be beneficial for consumers.

Q Okay. So let me make sure I understand what you're saying. That it's the closed physician hospital organizations and the management service organizations that you believe result in price increases without improvements in quality?

A And even the open physician organizations. There's some evidence in certain markets that prices rise.

Q But the fully integrated organizations, that's not the case?

* * *

[158] from Indiana, and I found out that there were – that it was not a metropolitan statistical area and I confirmed hat there were not a large number of hospitals in the area.

Q So your opinions regarding the thesis of your research, that is that there aren't gains in efficiencies or in quality of care, would apply equally in your expertise to the Lafayette area; is that correct?

MR. PENNELL: Object to form.

MS. WOODS: Join in the objection.

BY MR. ZAREMSKI:

Q Is that correct?

A It's my view that unless it's a fully integrated organization, that I would not expect to see any gains in efficiency or any increases in quality in Lafayette, Indiana. That's based on my training, my 20 years of research, and using that to look at the thousand plus hospitals, the 300 contracts, and the patient records across many markets.

Q Okay. And in terms of when you spoke of exclusive relationships, isn't it true it also extends to providing certain medical services on an exclusive basis; isn't that correct?

A I referred to two things earlier. One was that [159] if they were admitting physicians, they could not take their patients elsewhere. And two, whether they were – if they were not admitting, they could not work elsewhere – I am sorry – it could exclude other doctors from working at the hospital.

Q Okay. For which the exclusive services are being provided?

A Right.

Q Okay. So unless the particular area was fully integrated, as you just defined it, then the area would be not fully integrated, correct?

A Correct.

Q So an exclusive contract can exist in a not fully integrated model, right?

A Correct. And we have a hundred or so cases of those in our data.

Q Okay. And based upon your expertise, do you feel that you then can extrapolate from your search into the Lafayette market?

MR. PENNELL: Object to form.

MS. WOODS: Object to form.

BY MR. ZAREMSKI:

Q I'll withdraw the question.

Now, one of the states you reviewed was the State of Wisconsin?

[160] A Correct.

Q Do the demographics within that state – strike that.

The fact that you looked at data from the State of Wisconsin, as well as Florida and Arizona and now the Commonwealth of Massachusetts, does that impact at all upon your results that you looked at Wisconsin versus Florida versus Arizona and now Massachusetts?

MS. WOODS: Object to form.

BY MR. ZAREMSKI:

Q Does that matter at all in terms of the conclusions that you've reached?

A Well, it doesn't matter to the conclusions we reached. It matters to the generalizability of the results across all types of markets and all types of firms. We wanted a midwestern state which had lots of nonmetropolitan statistical areas, where there weren't lots of hospitals so we could ask whether things in small markets

in the midwest were different than they were in a place like Florida.

And the fact that across these three states and now Massachusetts we have a heavy managed care state like Arizona, we have a midwestern state like Wisconsin, we have a northeastern state like Massachusetts, which was heavily urbanized, and now Florida, which represents [161] the south, we feel pretty confident that it represents the cross-section of the country, the types of markets you would find across the country, including Lafayette, Indiana.

Q Okay. Thank you. Now I have in my notes, Doctor, and perhaps I'm wrong in what I heard, that in your question organizational forms, and if one of them is solely for the purpose of administrative functions, would there be or would there not be an effect on pricing and quality of care?

A The theory says there shouldn't be an effect on price or on efficiency, but there were people who hypothesized there could be an efficiency effect. That's one of the reasons we wanted to test those forms, and we rejected that hypothesis.

Q Therefore the result would be that there would be what?

A That there's no evidence that contracting purely for administrative services leads to efficiency gains. And the fact that large numbers of hospitals have abandoned that particular form suggests that they themselves weren't finding any efficiency gains or gains to this contract, and therefore they dissolved them.

Q You referenced an article by Mr. Gaynor?

A Yes.

[162] Q What was the nature of that article?

A By Gaynor and Haas Wilson. That was a discussion of basically changes in hospital market structure and the antitrust implications, and he looked both at horizontal and vertical arrangements. And there's a piece of that article which summarizes the theoretical hypotheses regarding transactions, costs, and market power that we test in this paper.

Q Now, you said further on that your market power hypothesis was found to be true after your research?

A Yeah. We concluded that in a large number of these cases, and specifically with exclusive contracts, we saw that these increased market powers as evidenced by increased price cost margins.

Q So when you also used the increase of 6 percent across the markets you studied, would it be within a reasonable degree of economic certainty that it would also apply to the Lafayette area?

MR. PENNELL: Object to form.

MS. WOODS: Object to form.

THE WITNESS: Well, if I were asked to extrapolate to the Lafayette area based on what I know, which is it is a small statistical metropolitan area and it's not a fully integrated form, I would say, based on the work I've done, that we would expect to see around a – [163] anywhere from a 13 to 26 percent increase rather than just a 6 percent increase.

BY MR. ZAREMSKI:

Q And that's said within a reasonable degree of economic probability?

A Yeah, that's said with the standards of the profession.

Q Thank you.

A And one of the things I want to clarify on price increase, it would be the case that without this prices might have fallen or might have stayed stable, that is they go 6 or 10 percent more than they would have otherwise. So what exact – so by comparing the price change before and after and saying that's not 13 percent is not evidence that this is wrong.

Q Okay. Does vertical integration models confer market power in some degree?

MR. PENNELL: Object to form.

MS. WOODS: Join in the objection.

THE WITNESS: There's literature – there's quite a bit of literature in the professional economics, in the academic economics literature published in peer-reviewed literatures which provides arguments and mechanisms by which vertical integration can confer market value, and some of those are listed in our paper.

* * *

AFFIDAVIT OF
WILLIAM STEPHEN MINORE, M.D., F.C.C.P., C.P.E.

If called to testify, I would state under oath to the best of my ability, belief and knowledge the following:

1. My name is William Stephen Minore, and I am a licensed physician whose specialty is anesthesiology. I am also head of an anesthesiology group, Rockford Anesthesiologists, Ltd. in Rockford, Illinois.

2. I am a member of the American Society of Anesthesiologists ("ASA"). A standard of the Society is that qualified personnel shall be in attendance at all times during the administration of general anesthetics to patients. This is the ASA's Standard I. A Certified Registered Nurse Anesthetist ("CRNA") can also be a qualified person when a patient is undergoing general anesthetics. It is my understanding that Lafayette Home Hospital and St. Elizabeth Medical Center in Lafayette, Indiana do not have in their employ CRNAs.

3. To not adhere to Standard I is to deviate from accepted standards of care for anesthesiologists. Further, to not adhere to Standard I for an anesthesiologist is to undertake conduct which can best be described as gross negligence. Further, if an anesthesiologist were to leave the hospital while a patient was anesthetized, that anesthesiologist should be professionally disciplined, sanctioned and have the Medical Board review his licensure.

4. Patient safety and quality of care for an anesthesiologist is not measured solely by patient outcome following a procedure in which the patient is under general anesthetics.

5. Quality in terms of patient care is measured by establishing a process so that an acceptable outcome for the patient can be expected or derived. This process includes following the generally accepted standards by an anesthesiologist attending a patient who is under a general anesthetic.

6. For an anesthesiologist to not attend a patient continuously and be present in the operating room continuously while that patient is under a general anesthetic and then assert that the patient received quality anesthesia care from the anesthesiologist because the patient awoke from a surgery without complications is like saying that a pilot who lands a plane safely with passengers aboard though he was absent for part of the flight (for example, by being asleep in the pilot's seat) did not place in jeopardy the lives of those passengers while he was absent. In both situations, the conduct of both the doctor and pilot fell deeply below, and deviated from, standards governing their respective professions' standards of care.

7. For an anesthesiologist who is part of an exclusive contract for anesthesia services to leave patients unattended for periods of time while those patients are under general anesthetics perverts the very reasons for which exclusive contracts are intended and places at risk the very lives and safety of those patients.

8. From my review of certain testimony provided in the lawsuit filed by Dr. Carolyn G. Kochert against Dr. Kenneth J. Bochenek, Greater Lafayette Health Services, Inc. and others in federal court in Indiana, it is my professional opinion that Dr. Bochenek and others in his group who have left patients unattended for periods of time while under general anesthetic have deviated from a

standard of career and committed what is essentially translatable into gross negligence.

9. An anesthesiologist should not record on an anesthesiology record within a hospital chart himself/herself being present in an operating room during the administration of anesthetics on a patient when there are periods of time in which the anesthesiologist is not present. Likewise, an anesthesiologist (or his group) should not bill for periods of time an anesthesiologist is away from the operating room during the administration of anesthetics upon a patient. This constitutes fraud.

To falsely fill out an anesthesiology record in a hospital chart by an anesthesiologist or to bill for an anesthesiologist being continuously present in the operating room when the anesthesiologist is not so present is a breach of a standard of care to which an anesthesiologist should and must adhere such conduct also impacts upon quality of care that patients as consumers are entitled to receive by their anesthesiologist.

Moreover, if such conduct occurs by an anesthesiologist within a group of anesthesiologists who have an exclusive contract to provide anesthesia services, the very nature and purpose for the existence of an exclusive contract becomes perverted.

10. An anesthesiologist has the responsibility and duty to record on the anesthesiology record as part of the hospital chart periods of time in which he or she is not continuously present in the operating room during the administration of anesthetics upon a patient.

11. Federal law prohibits billing for periods of time which an anesthesiologist is not continuously present in

the operating room during the administration of anesthetics upon a patient. Specifically, this law is Part B Medicare, Subject Number AN-001, and it is attached to this affidavit.

FURTHER AFFIANT SAYETH NOT.

/s/ William Stephen Minore MD
William Stephen Minore, M.D., F.C.C.P., C.P.E.

Date: August 21, 2003

SUBSCRIBED and SWORN to before me this 21 day of August, 2003

/s/ Jeanne M. Woodman
Notary Public

"OFFICIAL SEAL"
JEANNE M. WOODMAN
Notary Public,
State of Illinois
My Commission Expires
3/11/2007

SUPPLEMENTAL AFFIDAVIT

I Stephen Minore, M.D., do hereby state the following under oath to the best of my ability, knowledge and recollection:

1. This affidavit supplements the affidavit I signed and which was filed with the federal court in the Norther District of Indiana, Hammond Division at Lafayette, on August 29, 2003, and offers rebuttal opinions to those of expert reports filed on or before December 2, 2003 by experts retained by the defendants, particularly Dr. Barbara, in the case brought by Carolyn Kochert, M.D. against GLHS, Inc., John

Walling, AAPC and Kenneth Bochenek, M.D. in federal court in the Northern District of Indiana, Hammond Division at Lafayette.

2. I received and reviewed transcript of the depositions of Kenneth Bochenek ("Bochenek") and John Walling ("Walling") taken on November 4, 2003 and November 10, 2003. Attached to the Walling transcript was Exhibit 163, an un-redacted site visit report completed in December, 1997 by the American Society of Anesthesiologists ("ASA"). The transcripts of Bochenek and Walling became available from the court reporter on or about December 6, 2003. The ASA report also became available in an un-redacted form weeks after I executed my original affidavit.

3. The ASA report, from its wording and content, was a "smoking gun" in the sense that it should have placed Walling and others within the administration of Lafayette Home Hospital at the time on notice that there were significant problems regarding rendering of anesthesia services by the exclusive group headed by Bochenek, and particularly by Bochenek's rendering of services. The report put forth that Bochenek was away from the operating rooms for extended periods of time and described Bochenek in ways that did not promote in any way an open, free and non-hostile environment by those in anesthesiology. Due to the contents of the report, there should have been physician(s) assigned to intensively monitor and report on quality of care, including patient safety and reducing risk of harm, rendered by Bochenek and others within his group. This was not done. Left unchecked, as it has been at both GLHS hospitals, quality of care, including patient safety, would diminish and be inimical to the best interest of patients who have no alternative in a real practical sense but to accept services from

the exclusive group when patients required obstetrical and in-patient (greater than a 23 hour hospital stay) surgical services.

4. Walling dismisses the concerns of Dr. Kochert (and her colleague, Dr. Meyer) as coming from a "whiner" (pp. 66-67 of his transcript of November 10, 2003) when she presented real concerns related to patient safety by those, particularly Bochenek, rendering anesthesia services. This is unfathomable and deplorable. Equally, if not more reprehensible, is the complete denial by Bochenek, and also by Walling, that there were any compromises in patient safety or an increase in risk of harm, arising from anesthesia services provided by members of the exclusive group, notably by Bochenek. This smacks of a conspiracy of silence and a grade one cover up – all to the detriment of maximizing patient safety and providing quality of care. Walling has stated that the exclusive group has increased quality of care, but, in reality, the opposite has occurred.

5. I have reviewed the affidavit/report executed by Karen Williams, M.D. I agree with the contents of what she executed.

6. This Supplemental Affidavit is intended to rebut the report of Dr. Barbara in considerable ways, principally because he is not an anesthesiologist, he expresses only personal observations, his opinions are based on limited information and testimony, and he is not the most appropriate person to render views on ensuring quality of care, inclusive of patient safety and reducing risk of harm, to patients by anesthesiologist in the exclusive group at GLHS, Inc.

7. My assessment and opinions are consistent with paragraph 13 of Dr. Liang's report where he states: "Any analysis of the quality effects of the exclusive service arrangements must be based upon relevant data at the locale of the provision of healthcare."

FURTHER AFFIANT SAYETH NOT.

Date: December 9, 2003

/s/ William Stephen Minore MD
W. Stephen Minore, M.D.

SUBSCRIBED and SWORN to before
me this 9th day of December, 2003

/s/ Jeanne M. Woodman
Notary Public

"OFFICIAL SEAL"
JEANNE M. WOODMAN
Notary Public,
State of Illinois
My Commission Expires
3/11/2007

AFFIDAVIT OF KAREN S. WILLIAMS

If called to testify under oath, and to the best of my knowledge, recollection and belief, I would state the following:

1. My name is Karen S. Williams. I am a medical doctor whose specialty is anesthesiology. I have been in practice for 14 years. I am currently the Medical Director of Perioperative Services at St. Agnes Health care, 260-bed facility with 14 operating rooms, in Baltimore, Maryland. I am also Regional Vice President of North American Partners in Anesthesia of Maryland.

2. I am also currently the Chair of the American Society of Anesthesiologist's ("ASA") Committee on Surgical Anesthesia. The following duties of the committee are stated in Section 5.5152: Promote study and investigation in the field of surgical anesthesia, determine methods to provide good clinical anesthesia for all patients, and act as liaison representative to the various surgical organizations, including the American College of Surgeons. *The ASA is the largest professional association in the United States for anesthesiologists.*

3. Attached hereto as Exhibit A is the Policy Statement on Practice Parameters adopted by the ASA House of Delegates in 1993 and last revised in 1999. That Statement provides, in part, that practice standards are rules or minimum requirements for clinical practice.

4. Attached hereto as Exhibit B as the Practice standards for Basic Anesthesia Monitoring adopted by the ASA House of Delegates in 1986 and last revised in 1998. Standard I state that qualified anesthesia personnel shall be present in the room throughout the conduct of all general anesthetics, regional anesthetics and monitored anesthesia care.

5. My comment as a practicing clinician, and not on behalf of the ASA House of Delegates, is that Standard I was developed to enhance patient safety.

6. Due to rapid changes in patient status during anesthesia, qualified anesthesia personnel shall be continuously present to monitor the patient and provide anesthesia care. Continuously is defined as "prolonged without any interruption at any time." In the event that an emergency requires the temporary absence of the person primarily responsible for the anesthetic, the best

judgment of the anesthesiologist will be exercised in comparing the emergency with the anesthetized patient's condition and in the selection of the person left responsible for the anesthetic during the temporary absence.

Further affiant sayeth not.

/s/ Karen S. Williams
Karen S. Williams

Dated: [August] ~~July~~ 12, 2003

SUBSCRIBED and SWORN
to before me this 12th day of
August, 2003
/s/ Carolyn A. Ingal
Notary Public

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF INDIANA
HAMMOND DIVISION AT LAFAYETTE

CAROLYN KOCHERT, M.D., Plaintiff, vs. GREATER LAFAYETTE HEALTH SERVICES, INC., d/b/a ST. ELIZABETH MEDICAL CENTER, and d/b/a/ LAFAYETTE HOME HOSPITAL, ANESTHESIOLOGY ASSOCIATES, P.C., JOHN WALLING and KENNETH BOCHENEK, M.D., Defendants.	) CIVIL NO. 4:01CV27AS) DEPOSITION OF DR. WILLIAM STEPHEN MINORE) 12-19-03

Deposition of DR. WILLIAM STEPHEN MINORE, a witness of lawful age, taken on behalf of the defendants, Anesthesiology Associates, P.C., John Walling and Kenneth Bochenek, M.D., in the above-entitled cause, wherein Carolyn Kochert is the plaintiff and Greater Lafayette Health Services, Inc., et al. are the defendants, pending in the District Court of the United States for the Northern district of Indiana, Northern Division, Hammond Division at Lafayette, before Deb Fisher, Notary Public in and for Winnebago County, Illinois, in the offices of Rockford Anesthesiologists Associated, 2202 Harlem Road in the City of Loves Park, State of Illinois, on the 19th day of December, 2003, commencing at 4:30 p.m., as reported and transcribed by Deb Fisher, Certified Shorthand Reporter in and for the state of Illinois.

* * *

[38] before there was really a board certification for pain management. And I also teach at the review course.

Q. Do you practice in any facilities other than the two hospitals that you mentioned, SwedishAmerican and Saint Anthony's?

A. The Rockford Ambulatory Surgical Center, and Northwest Suburban Community Hospital, which is a bariatric center. And occasionally I'll go out to Freeport Memorial Hospital and do a case or two out there just to see what's going on. That's one of the hospitals that my group covers.

Q. Does your group have any exclusive services arrangement at any of these facilities?

A. We have an exclusive arrangement at SwedishAmerican. At Saint Anthony's we have an exclusive, save for two independents who are not affiliated. Freeport we have an exclusive anesthesia arrangement, and the surgery center we have an exclusive arrangement.

Q. From your point of view as a practitioner, do you recognize the benefits to having these exclusive arrangements for you or your practice group?

A. Well, with an exclusive arrangement it gives you [39] a lot more responsibility and accountability, which is good, because the whole idea of an exclusive arrangement is for public policy issues that you improve the quality of care, because the hospital administrator, when there's something wrong, doesn't have to have four individuals all pointing divergent fingers at one another.

From the issue of discipline, there are certain unique problems that an exclusive arrangement does engender,

but if handled appropriately, those could be overcome; i.e., QA issues. But like anything, they can be abused.

I feel in this case that they were abused, but I also feel that exclusive arrangements were public policy issues in radiology, anesthesiology, pathology, and ER because the hospital has a fiduciary responsibility to the community to provide comprehensive, continual and quality care. And with the anesthesia in the past, prior to the utilization of exclusive arrangement, you would have heterogenous individuals and there would be no way to get them to do anything that the hospital wanted; i.e., provide continuous coverage.

* * *

STATE OF INDIANA	)	IN THE TIPPECANOE
	)	SUPERIOR COURT
	)	SS:
COUNTY OF TIPPECANOE	)	CAUSE NO.
	)	79D02-0003-CP-00045

CAROLYN G. KOCHERT, M.D.,	)
Plaintiff,	)
	)
v.	)
	)
KENNETH J. BOCHENEK, M.D.,	)
	)
Defendant.	)

DEPOSITION OF CORNELIUS A. HOFMAN

February 4, 2004

Boise, Idaho

(1) Present Value of Economic Loss: March 1998 through February 1999 (see Table 5u)

From	Through	Years	Average Hours Worked per Week	Average Hours Worked per Week in 1997	Ratio to 1997 Weekly Hours	1997 Earnings	Inflation Factor to Convert 1997 Earnings to 2003 $	1997 Earnings in 2003 $	Projected Period Earnings in 2003 $	Actual Annual Earnings	Actual Period Earnings	Inflation Factor to Convert Actual Period Earnings to 2003 $	Actual Period Earnings in 2003 $	Present Value of Estimated Loss
Mar-98	Dec-98	0.83	88.0	50.0	1.76	$446,386	1.1411	$509,360	$744,073	$468,380	$388,755	1.1236	$436,795	$307,278
Jan-99	Feb-99	0.17	73.3	50.0	1.47	446,386	1.1411	509,360	127,289	578,631	98,367	1.0993	108,135	19,154
													Total	$326,432

(2) Present Value of Economic Loss: March 1999 through July 2000 (see Table 5u)

From	Through	Years	Average Hours Worked per Week	Average Hours Worked per Week in 1997	Ratio to 1997 Weekly Hours	1997 Earnings	Inflation Factor to Convert 1997 Earnings to 2003 $	1997 Earnings in 2003 $	Projected Period Earnings in 2003 $	Actual Annual Earnings	Actual Period Earnings	Inflation Factor to Convert Actual Period Earnings to 2003 $	Actual Period Earnings in 2003 $	Present Value of Estimated Loss
Mar-99	Dec-99	0.83	73.3	50.0	1.47	446,386	1.1411	509,360	621,470	578,631	480,264	1.0993	527,952	93,519
Jan-00	Jul-00	0.58	64.0	50.0	1.28	446,386	1.1411	509,360	378,149	402,766	233,604	1.0635	248,449	129,700
													Total	$223,219

(3) Present Value of Economic Loss: August 2000 through working life (see Table 10u and 11u)

Year	To Age	Percent of Year	Expense Base	Age-Education Life Cycle Factor	Life-Cycle Adjusted Money Earnings	Worklife Adjustment Factor	Present Value of Loss (Lower Bound)	Present Value of Loss (Upper Bound)	Cumulative Loss (Lower Bound)	Cumulative Loss (Upper Bound)
2000	46.37	42%	$99,600	1.00000	$99,600	0.95694	$40,031	$40,031	$40,031	$40,031
2001	47.37	100%	99,600	1.00000	99,600	0.95694	95,311	95,311	135,342	135,342
2002	48.37	100%	99,600	1.00000	99,600	0.95694	92,535	94,367	227,877	229,709
2003	49.37	100%	99,600	1.00000	99,600	0.95694	89,840	93,433	317,717	323,142
2004	50.37	100%	99,600	1.00000	99,600	0.95694	87,223	92,508	404,940	415,650
2005	51.37	100%	99,600	1.00000	99,600	0.95694	84,682	91,592	489,622	507,242
2006	52.37	100%	99,600	1.00000	99,600	0.95694	82,216	90,685	571,838	597,927
2007	53.37	100%	99,600	1.00000	99,600	0.95694	79,821	89,787	651,659	687,714
2008	54.37	100%	99,600	1.00000	99,600	0.95694	77,496	88,898	729,155	776,612
2009	55.37	100%	99,600	1.00000	99,600	0.95694	75,239	88,018	804,394	864,630
2010	56.37	100%	99,600	1.00000	99,600	0.95694	73,048	87,147	877,442	951,777
2011	57.37	100%	99,600	1.00000	99,600	0.95694	70,920	86,284	948,362	1,038,061
2012	58.37	100%	99,600	1.00000	99,600	0.95694	68,855	85,430	1,017,217	1,123,491
2013	59.37	100%	99,600	1.00000	99,600	0.95694	66,849	84,584	1,084,066	1,208,075
2014	60.37	100%	99,600	1.00000	99,600	0.95694	64,902	83,746	1,148,968	1,291,821
2015	61.37	100%	99,600	1.00000	99,600	0.95694	63,012	82,917	1,211,980	1,374,738
2016	62.37	100%	99,600	1.00000	99,600	0.95694	61,176	82,096	1,273,156	1,456,834
2017	63.37	100%	99,600	1.00000	99,600	0.95694	59,395	81,283	1,332,551	1,538,117
2018	63.50	13%	99,600	1.00000	99,600	0.95694	7,692	10,553	1,340,243	1,548,670
							$1,340,243	$1,548,670		

EX. NO. 271
DATE
ASSOCIATED REPORTING, INC.

AFFIDAVIT OF ANTHONY D. IVANKOVICH, M.D.

If called to testify under oath, I would state to the best of my ability, knowledge and belief the following.

1. My name is Anthony D. Ivankovich. I am a medical doctor who has been practicing medicine with a specialty in anesthesiology since 1970. I am head of University Anesthesiologists, a group of approximately 50 anesthesiologists in private practice. I am also Associate Vice President and Director, Surgical Services at Rush-Presbyterian-St Luke's Medical Center and Rush University, Chicago, Illinois. A copy of my abbreviated curriculum vitae is attached to this affidavit.

2. I am a member of the American Society of Anesthesiologists ("ASA"), the largest professional association in the United States for anesthesiologists.

3. Standard I of the ASA states, "Qualified anesthesia personnel shall be present in the room throughout the conduct of all general anesthetics, regional anesthetics and monitored anesthesia care." Qualified personnel include anesthesiologists or Certified Registered Nurse Anesthetists ("CRNA").

4. Members of the ASA should abide by the standards of the ASA.

5. Based upon my years of experience, Standard I means just what it says, and that qualified anesthesia personnel should be present continuously in the operating room while the patient is being administered general anesthetics. This opinion applies to any anesthesiologist in

whatever health care facility he or she practices – whether in urban areas or in semi-rural or rural area.

6. For an anesthesiologist to leave a patient unattended for period(s) of time without the presence of qualified and experienced anesthesia personnel jeopardizes the health and safety of a patient and diminishes the quality of care provided that patient, regardless of the outcome to the patient. For an anesthesiologist to leave a patient so unattended even if the patient's health and welfare are not affected at the conclusion of the case would be, by way of analogy, like an airplane pilot falling asleep during an airplane flight, only to wake up before landing, assuming the controls and having the passengers safely arrive at their destination.

7. If a hospital does not have CRNAs on its staff, the only qualified anesthesia personnel in the operating room would be the anesthesiologist.

8. An anesthesiologist should not record on an anesthesiology record within a hospital chart himself/herself being present in an operating room during the administration of anesthetics on a patient when there are periods of time in which the anesthesiologist is not present. Likewise, an anesthesiologist (or his group) should not bill for periods of time an anesthesiologist is away from the operating room during the administration of anesthetics upon a patient. To see either of these is a foundation for disciplining the physician or group. To bill

for anesthesia services not rendered is tantamount to fraudulent conduct on the part of the billing entity.

FURTHER AFFIANT SAYETH NOT.

/s/ Anthony D. Ivankovich, M.D.
Anthony D. Ivankovich, M.D.

Dated: August 11, 2003

SUBSCRIBED and SWORN to before me this 11th day of August, 2003

John F. Ranos
Notary Public

OFFICIAL SEAL
JOHN F. RANOS
NOTARY PUBLIC,
STATE OF ILLINOIS
MY COMMISSION
EXPIRES 5-29-2007

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF INDIANA
HAMMOND DIVISION AT LAFAYETTE

CAROLYN G. KOCHERT, M.D., Plaintiff,	)	
vs.	)	CIVIL NO. 4:01CV27AS
GREATER LAFAYETTE HEALTH SERVICES, INC., d/b/a ST. ELIZABETH MEDICAL CENTER, and d/b/a LAFAYETTE HOME HOSPITAL, ANESTHESIOLOGY ASSOCIATES, P.C., JOHN WALLING, and KENNETH BOCHENEK, M.D., Defendants.	)	

CONTINUED DEPOSITION OF DOUG EBERLE

The continued deposition upon oral examination of DOUG EBERLE, a witness sworn to before me, Maria S. Estes, a notary public in and for the State of Indiana, taken on behalf of the plaintiff, at the Law Offices of Stuart & Branigin, 300 Main Street, Lafayette, Indiana, on the 14th day of April, 2003, pursuant to the Indiana Rules of Trial Procedure with notice as to the time and place thereof.

* * *

[55] Q So economics did not play into it?

A Economics played into it in that prior to signing an exclusive agreement anesthesiologists charged whatever they wanted for the provision of anesthesia services. Once we signed an exclusive – or once we signed an exclusive contract in [56]

anesthesia the hospital then was able to effect what charges of the group the patients received.

Q Am I correct in understanding then that an exclusive contract, including the one you signed with Dr. Farrell back in – capped charges for anesthesiology services?

A I wouldn't say they capped charges. The contract had an agreed upon rate that would be charged.

Q And I believe it's per unit?

A Yes.

Q I think that's how it would be worded. Now is that having a contract with a specific charge, does that benefit the hospital back in '98 – St. Elizabeth – would that be beneficial for the hospital?

A Definitely.

Q Why?

A Because we would be able to tell patients what an estimated – the estimated cost was going to be for a particular procedure. Prior to that anesthesiologists charged whatever they wanted.

* * *

[59] Q Okay. In what way would the anesthesiology group participate with third party payors?

A They would have an agreement as to what they – it would charge a patient for whom a third party was paying the bill.

Q And would that be a favorable development from the third payor's perspective?

A Well, I can't speak for the third party payors, but I would think so.

Q Okay. And would it be a favorable development from the hospital's perspective?

* * *

A It favors the hospital because that means a third party payor would not be over charged at the hospital for something that the hospital [60] **did not control prior to contract.**

Q Now you use the word over charge. How would you know that – and again, we're talking about the '98 timeframe – how would you know that the third party payor would be over charged?

A In negotiations with third party payors they would ask to have an agreement with the hospital-based physicians.

Q Was it that the third party payors were to ask for an agreement, is that right?

A Yes.

Q Between – now this agreement would be between whom?

A Between the third party payor and the physicians providing services in the hospital.

Q Now having such an agreement, would that benefit the hospital as well?

A Yes.

Q In what way would that benefit the hospital?

A The third party payors would not discourage their covered lives from coming to St. Elizabeth.

* * *

The lower courts failed to explain why the propositions set forth in the left hand column were insufficient to overcome the courts' empirical conclusions, which are set forth in the right hand column.

Response	District Court
Eberle testified that GLHS did have an economic interest in the exclusive contracts for anesthesia services. App. 128-131.	Petitioner's tying claims were deficient because GLHS had no economic interest in the anesthesia services provided by AA. App. 25.
Exclusive contracts can become illegal if used to foreclose competitors in markets controlled by those having market control. Seaman has already defined with admitted testimony the product and geographic markets, Respondents' market control, and undertook a satisfactory dynamic analysis of the markets. *See* references to Seaman in Petition.	The group boycott claims are illegal only if used to enforce agreements that are illegal. App. 26.
Petitioner has shown harm to competition through decreased quality (Minore, Ivankovich); pricing (Seaman, Gertler) (*see* references in Petition); and output (deposition testimony, GLHS consultant's report, and Minore's testimony.)	Petitioner failed to show actual harm to competition. App. 27.
Gertler testified that pricing increased 13-26%; the norm is about 6% for such contracts. App. 108-109. Seaman testified to an increase of	There was no evidence to suggest that prices have increased beyond those in Lafayette and other parts of Indiana. *Id.*

20% based on quality of care issues. App. 98.	
Minore testified to the exclusive group abusing the exclusive arrangements (App. 121), and there was no evidence of this abuse before the contracts were first executed; also, market power was first established in 1997, per Seaman's analysis (App. 89), without evidence that it existed to the contrary before this time.	Petitioner failed to show that quality of care was reduced after the exercise of market power. App. 27.
Seaman did a dynamic analysis found acceptable by the district court and which showed patients did not have a choice. App. 45-46. Any differences could be tested by cross examination. *Id.*	There was no harm to competition because patients could choose to go elsewhere. App. 28.
Seaman established the relevant product market (App. 38-41), the relevant geographic market (App. 41-45), and market power (App. 82-86, 89). Also, it is this Court's law that once testimony is admitted, it is not just reliable, but relevant as well. Relevancy = materiality. What was at issue in *Daubert* was not, as the district court stated, reliability and methodology, because methodology	Petitioner failed to adequately define the relevant markets (App. 28, n.3), failed to show GLHS had market power to restrain trade (App. 27), and that the methodology employed by Seaman and its reliability were only at issue when the court decided its *Daubert* ruling. (App. 30, n.4)

is *only part of* reliability; the other prong is relevancy.

Seaman's LOFI-LIFO analysis was found relevant and reliable by the district court. App. 41-45, relying upon the 7th Circuit's decision in *Rockford Memorial* as prevailing law. The district court relied on cases that were bench proceedings without any *Daubert* analysis. App. 29-30. These were the very same cases that the district court distinguished in its *Daubert* order. App. 42. ("The court also finds it significant that the cases cited by the defendants to support this argument did not involve *Daubert* challenges.") *Id.*

Petitioner's geographic market was too narrow, referencing inadequacy of LIFO-LOFI. App. 29-30.

The district court found Seaman did not ignore commercial realities because of the dynamic analysis he did of the geographic markets found relevant and reliable. App. 45-46. Seaman recognized that there could be other hospitals patients might go to, but that they were not viable alternatives. App. 46.

Petitioner ignored the commercial realities of Lafayette. App. 30.

This case is not about the merger of the hospitals, but

Respondents' actions were pro competitive, referring to

the anticompetitive effect of exclusive contracts (on the marketplace and competitors) whose signatories controlled the market. Gertler testified that these contracts did not produce efficiencies. App. 101 (¶3) (exclusive contracts produce no cost savings), 105 ("I would not expect to see any gains in efficiency or any increases in quality in Lafayette, Indiana.").	GLHS' closure of the OB unit at SEMC. App. 31.
Testimony provided by Walling and Bochenek established that the master exclusive dealing contract between GLHS and AA was not in existence in 1998, yet Petitioner was told by Bochenek in 1998 that it was – requiring her to still have a subcontract. Proofs in the record show this.	There was no conspiracy to monopolize. App. 31-32.
There was no state court order that dismissed the claims Petitioner asserted regarding the non existence of the master contract. Proofs in the record show this.	*Res judicata* applied (App. 33).
Hofman calculated damages to Petitioner from 1998-2018. App. 124. Hofman used 1998 as the starting point for this calculation. Damages continued because Petitioner was never allowed	Damages arose solely from the denial of the exclusive contract. App. 23.

to reenter the anesthesiology services market, through 2002-2003 (App. 4). From previous references as well, Seaman established that anti-trust activity commenced in 1998 too, and went forward into 2001 and beyond. App. 91.

There is no prevailing law that states harm to a competitor must be the same harm caused to the competition. A competitor's harm can be economic loss to one's business (*Angelico*), and harm to competition is measured by a decrease in quality, an increase in pricing or a decrease in output (*see* citations in the Petition, *supra*). Both injuries arose out of the same anti-competitive behavior – the operation of the exclusive dealing contracts in relevant markets by signatories which had market control – already established by Seaman's testimony.

Petitioner did not show harm to competition, but only harm to herself; but her harm did not result from increased prices for anesthesia services or diminished anesthesia services as she asserted occurred to the competition. App. 24.

Response

Seaman testified that the sequence of events commenced in 1998. App. 91. This was the first instance where Respondents exercised their market control to exclude a competitor.

Appellate Court

Petitioner could not present any evidence that any of the events of 1998 were part of an anti competitive scheme. App. 13.

Hofman established continuing economic loss into 2018. App.124. Petitioner also was ready, willing and able to reenter the anesthesiology market as late as 2003. App. 4. Even if 2001 were a starting point, Petitioner was still a competitor in markets defined by admitted expert testimony with Respondents exercising market power (App. 89), and who sustained continuing economic loss into 2018 (App. 124).	Petitioner suffered no antitrust injury in 2001, because she was out of the market by then. App. 14-15.
Seaman testified antitrust activity started in 1998 and went forward; not starting in 2001 and looking backward. App. 89, 91, 95.	Petitioner attempted to post date her participation in the market as proof of antitrust injury. App. 14.
The court totally disregarded Petitioner's main expert on pricing, Gertler. Prices were considerably affected by the exclusive contracts, rising 13-26% above the norm of 6%. App.108-109. Overpricing due to the contracts was an easy 20% due to diminution in the quality of care provided to patients by the exclusive group. App. 98 (Seaman).	Petitioner ("and 'her expert'") had no evidence that prices were affected by anticompetitive activity. App. 17.
The court completely ignored Gertler's testimony on pricing, as noted, *supra*.	Petitioner relied exclusively upon quality of care as proof of anticompetitive effect and

as proof of "quality adjusted" costs. App. 17.

Such evidence was tantamount to gross negligence, per Minore. App. 111-112 (leaving patients unattended for periods of time deviates from a standard of care and is essentially translatable into gross negligence). Qualified as reliable by the district court, he didn't require a statistical analysis to form his opinions based on the record. The exclusive group abused its contracts by the quality of care it rendered to patients. App.121 In discussing the "anecdotal" evidence Minore relied upon of which the (appellate) court was critical, though not constituting manifest error, the district court stated that Minore relied upon sufficient [anecdotal] testimony from other witnesses, so that his testimony should not have been excluded. App. 57. The district court opined if there was any "shoddiness" from reviewing limited testimony of others that he relied upon, it could be tested through cross examination and the presentation of

Petitioner's use of anecdotal evidence and physician affidavits to substantiate diminished care rather than statistical analyses is not useful. App. 17.

contrary evidence. *Id.* Proofs also exist in the record showing that the reason the exclusive contracts were entered into had only to do with anesthesiologists covering GLHS hospitals in 1994, and not deficient quality of anesthesia care.	
Evidence was provided by the admitted expert testimony of five highly qualified experts, dozens of affidavits, and many depositions (all on quality, pricing, and output) ignored or weighed by the court.	The record is bereft of credible evidence of the type of anticompetitive effects alleged by Petitioner.